

A Critical Analysis of UK International Health Partnerships: The Discourse of Mental Health

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DEDICATION

I would like to dedicate the completion of this thesis to my God in whom I find purpose and peace and my wife Reanne who has supported me in so many ways from day one. To the two of whom I am eternally grateful.

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ABSTRACT

Background

The work of International Health Partnerships (IHPs) is a way of working with Low- and Middle-Income Countries to address issues of Global Health and more recently Global Mental Health. They have come about through various political constructs such as over the Millennium Development Goals. The researcher provides an overview for the political context before using a scoping review to demonstrate the gaps in existing literature. These gaps informed the construction of this research which aimed to explore how the work of IHPs is communicated and how these forms of communication related to the wider debate surrounding the ethics and utility of IHPs.

Method

The researcher carried out a Critical Discourse Analysis on project reports that documented the progress of IHPs addressing mental health concerns. The analysis critically explored the structural and discursive features of these documents.

Results

The results obtained highlighted issues with the construction of the documents used to capture development, as well as concerns about the rhetorical devices and discourses used in the communication of IHP work which constituted a form of testimonial injustice.

Conclusion

In order to progress to an equitable form of health partnership changes need to be made at all levels to take make the rhetoric around the good of global health more than hollow words.

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1 INTRODUCTION

The overall aim of this chapter is to help the reader situate the work of International Health Partnership's (IHPs) within the context of the globalisation of mental health (MH). As there are various layers of context, this chapter begins by framing the political and historical context that has given rise to the globalisation of health. Following which, the reader is guided through the various layers of context to understand IHPs as a distinct way of working within global health.

1.1 Research Context

Historically, scientific research has taken a realist ontology and epistemology, in its attempts to convey what can be known as 'real' and 'true' about our world. from which (Diebel, 2008). As such, researcher neutrality was positioned as a qualifying characteristic of research, as it implied that what was being conveyed was objective and therefore legitimate. However, the use of different ontological and epistemological positions brought challenges to what could be considered 'real' and 'true', along with which came questions about the utility of concepts such as neutrality. Thinkers have challenged the idea that research can be somehow free from bias, or divorced from the researcher's "perspectives, background, position or conditioning circumstances" (Diebel, 2008, p. 555), and concluded that neutrality is in itself an impossible goal. Moreover, these researchers have acknowledged that the relationship between the observed and the observer are inextricably linked. Thus, in order for the objectivity of research to be scrutinised, it becomes imperative that researchers utilise reflexivity in the creation of research (Snape & Spencer, 2003). Reflexivity illuminates the connections between the object and the observer, thereby making transparent the factors that could have potentially influenced the research practices. Furthermore, once aware of these factors, researchers should document this information alongside the technical details of how the research was conducted. In light of this, this research provided contextual information about the researcher to facilitate the evaluation of objectivity and

bias. Although this practice is not yet a requirement in research, its use appeared ethically imperative for the progression of social science research.

1.1.1 Researcher Background

Although being born in the United Kingdom (UK) and identifying as British, the researcher would also identify themselves as Afro-Caribbean. The lived experience of these identities has created intimate connections with both individualist and collectivist world views, and has influenced various areas of their life. Of pertinence to this research were their views on self-other relations, power and injustice. Regarding self-other relations, having lived and studied in various countries around the world the researcher developed a distinct connection with a number of concepts. Firstly, the idea that the links between people, be it race, culture or even values are of significance in the conception and perception of the self. Moreover, the idea that the individual has a responsibility to the collective from which it draws its sense of self. Regarding power, part of the fabric of the researcher's social and material world carried the consequences of how power was used to export the worldviews and organisational systems of one culture imposed onto another. Lastly, regarding injustice, the researcher witnessed the effects of social inequality on the MH, education and employment of those around them. They also learnt about the disparities in the treatment of people by the institutions designed to address the aforementioned issues. They were impacted by the knowledge that these disparities in treatment were rooted in differences of identity. However, they were also impacted by the stories of resistance from those subjected to these treatments, and pressure for accountability of those who were involved in delivering said treatment.

Each of these elements have influenced the research. The collectivist views have influenced the orientation taken towards what can be known and how these things can be known. The experiences of power have influenced the researcher's choice to explore relationships where there are differences in power. The experiences of injustice have influenced the researcher to explore relationships with institutions with scepticism towards the ethics underpinning the work being carried out. Combined, these influences produced a desire within the researcher to contribute to meaningful change within "caring"

institutions. Change that would impact the lived experiences of those who come into contact with these institutions.

1.1.2 Naivety And the Critical Perspective

The researcher also developed an interest in the type of treatment being received by people in Low- and Middle-Income Countries (LMIC's), specifically in relation to their MH. Over time this interest grew into a desire to contribute to the development of MH services in LMIC's. However, during the course of their academic career the researcher was introduced to how to evaluate ideas from a critical perspective. This perspective was in turn cast upon the researcher's desire to engage with LMIC's, which forced the researcher to go beyond the practical questions such as "how would one develop services?", and "what development might look like?". To the more abstract questions such as "what were the ideas of development founded on" and "what would be the impact of using these models of development in another social context?". In attempting to answer these more critical questions, the researcher became more aware of how complex it could be to work with models of MH outside the UK context. Moreover, the researcher became aware of both the potential to be of benefit and the potential to do harm connected with this way of working.

1.2 Relationship to Clinical Psychology

The researcher came across IHP's as a way of working through meeting several Clinical Psychologists (CP's) who were contributing to the work being done within an IHP. The concept of the IHP was new to the researcher and as such they became interested in how CP's were involved in this process. The researcher was drawn to thinking about the involvement of psychology as a profession in the history of MH within High Income Countries (HIC's). With its participation ranging from passive observer, to complicit participant, right on to advocate for political and social change. The combination of these events influenced the researcher's decision to explore relationships involved in IHP's, as well as the potential implications arising from these relationships.

Traditionally, the role of Applied Psychologists as scientist and practitioner has given legitimacy to its contributions, allowing the knowledge produced to be included alongside those of other scientists and researchers within the health profession. The role of the Applied Psychologists such as CP's has changed with time, and as such, so too have the spaces where they are able to enact their roles. With increased emphasis on leadership and service development (Prescott et al., 2014) CP's are aptly positioned to both directly contribute to the new ways of working and critically appraise the work being completed on national and international levels. Imbedded within the CP code of ethics and conduct (British Psychological Society, 2018) is the philosophy that CP's have a professional responsibility to be aware of the professions' power of influence. Therefore, CP's are to ensure that the implications of their actions are properly managed. Consequently, as CP's move into new ways of working, such as IHP's, there is an ethical imperative to evaluate these ways of working, and account for the ways in which professional power has been used (Toogood, 2010). Although such evaluations can be done informally within organisations, the CP's role as a scientist practitioner also substantiate the argument for more formal evaluations in the form of research.

1.3 Globalisation

The literature pertaining to the interactions of organisations across geographical locations often uses the term 'Globalisation'. Globalisation is a term that has gained increased importance in many fields over the last half century, beginning with the fields of business and technology. However, there is little agreement about the origins of globalisation as a process (Hanefeld, 2015; Lee, 2004a). Held et al (1999) identified three dominant historical viewpoints of globalisation, namely the sceptical approach, the hyperglobalist approach, and the transformationalist thesis. The sceptics used statistical data pertaining to the flow of trade, investment and labour around the world spanning several centuries. Some sceptics speculate that globalisation goes as far back as Christopher Columbus setting sail "to conquer the new world on behalf of the Spanish Crown" (Guttal, 2007, p. 524). As such, they assert that there is evidence of global connections of economic interdependence throughout time,

which have been built on previous developments. Where some view the developments as natural and neutral progressions, the Sceptics see developments as “the result of specifically conceived, planned, and targeted neo-liberal policy and structural measures that sought to bring all aspects of social, economic, and political life under the rubric of market capitalism” (Guttal, 2007, p. 525). They assert that globalisation is an exaggerated myth, as the level of trade indicate what could be classed as internationalisation, but as they do not constitute a perfectly integrated worldwide economy it cannot be seen as globalisation. The hyperglobalist approach on the other hand, recognises the importance of historical developments, but assert that there was a turning point in history (i.e. the invention of the microprocessor which led to the establishment of the first global networks) from which globalisation arose. With the emergence of the single global market and global competition the Hyperglobalist hold the belief that “economic globalisation is constructing new forms of social organisation that are supplanting, or that will eventually supplant, traditional nation-states as a primary economic and political unit of world society” (Held et al., 1999). This process of supplanting existing structures will lead to the development of transnational networks of finance, production, and trade. The transformationalist thesis builds on the hyperglobalist belief about the transformative power of globalisation. They argue that globalisation is itself the underlying force responsible for the rapid and widespread transformations reshaping and reconstructing modern society (Rennen & Martens, 2003). While there is little agreement about its origin, the three schools of historical thought do agree that globalisation has been built upon two pillars. The first pillar is capitalism, which represents a distinct ideological shift from the methods of trade that preceded it. Whilst more traditional forms of trade may have exchanged goods and services for other goods and services, capitalist ventures focus on the forms of exchange that generate monetary value to the exclusion of all else. The other distinction lies in the way in which surplus wealth is used. Traditional forms of trade often held the surplus wealth in reserve or used it in the acquisition of items of status, such as prestigious buildings, jewellery and fine art. Capitalist trade uses surplus wealth as a form of reinvestment capital through which it can expand its ventures and acquire more wealth. The second pillar undergirding globalisation is technological innovation. With the electric telegraph communication being freed from the time and space

limitations imposed by reliance on physical means of transport, it utilised other advancements such as steam technology to extend the reach of trade and thus the range of items that could be traded.

Each of the aforementioned viewpoints has asserted the importance of specific factors in the development of globalisation, and thus made it difficult to have a clear definition of the process. Moreover, as use of the term has spread to a wider array of fields, the complexity of how the processes operate has also increased. Thus intensifying the debate about how to define 'globalisation'. Rennen & Martens (2003) proposed a multidimensional and pluralistic definition of globalisation as:

“An intensification of cross-national, cultural, economic, political, social and technological interactions that lead to the establishment of transnational structures and the global integration of cultural, economic, environmental, political and social processes on global, supranational, national, regional and local levels”.

If a multidimensional definition of globalisation was adopted, then in contemplating the impact of globalisation, thought would need to be given to the various dimensions. Rennen & Martens (2003) emphasise the need to think of globalisation as part of a political process. They assert that globalisation has at times been used as a tool of political decisions and government legislation, as well as used to inform decisions and the construction of legislation. One example of this would be the political decisions made in the wake of the First World War. The high financial cost of the war was seen as influencing many nations to focus efforts on “establishing strong national economies and decreasing economic dependence” (Rennen & Martens, 2003, p. 141). These decisions led to the nationalisation of many businesses that formed the infrastructures for economic production (e.g. mines, and power stations) and infrastructures for exportation (e.g. railways). Following the Second World War arose the recognition that international cooperation was necessary to prevent further world wars. This agenda informed a number of decisions made by nation states about providing aid and supporting development in foreign countries. Alongside this, the use of laissez-faire and free trade politics within countries like the UK, expanded international economic activity. The success of the economic policies saw the UK and the US become two of the main political and

economic powers. The combination of these factors in turn spurred the adoption of globalisation and led to the creation of international production networks and intergovernmental organisations such as the United Nations (UN). These international bodies went on to become the largest contributors of data on international need, which has in turn influenced many of the political decisions since their inception. In recent years, The World Bank has given its support to the use of globalisation based on its assessment that looked back over 40 years of development across the world (1960-2000). They asserted that “for many of the poorest least-developed countries the problem is not that they are being impoverished by globalization, but that they are in danger of being largely excluded from it” (2000, p. 2). Their assessment was that the more globalised developing countries increased their per capita growth by 1 percent each decade (reaching 5 percent in 1990’s), while the less globalised developing countries were only able to achieve a 0.4 percent share of world trade.

Although globalisation has been largely spoken of in positive terms, the insurgence did not occur unchallenged. In fact, the capitalist philosophy within globalisation contributed to international tensions between the West and the Eastern Block, who had adopted a communist economic agenda. These tensions mounted and became the Cold War (1946-1991). As evident in this example, much of the economic, political and social change present around the world could be understood as been influenced by globalisation. However, historically depending on factors such as geographical location, age, sex, ethnicity, education attainment, and socioeconomic status aspects of globalisation have brought either widespread benefits or costs (Lee, 2004a). As globalisation has continued to play a part in the way that societies change, it is important that attention is given to the factors that influence it, when seeking to understand the change in transnational interactions.

1.4 Globalisation and Health

The following section documents how the agendas of international cooperation and economic growth have fuelled globalisation, and in turn led to changes in the health landscape.

1.4.1 Political Emergence of “Health for All”

Despite the global population having doubled from 1 to 2 billion in the hundred years between 1825 and 1925, the average life expectancy varied greatly between nations. By 1950 it was possible to compare data for all the world regions. This comparison highlighted that the average life expectancy of a person living in Africa was 35 years old, compared to that of a person living in Europe which was almost double at 64 years old (Roser, 2019). Life expectancy, along with mortality were seen as significantly influencing these countries development potential. Thus, it was recognised that in order to generate economic development, the health of the workforce would need to be addressed. Yet, as each nation had its own interest driving the distribution of funds, international aid was adopted as a way to bring about change in the areas of concern. Lee (2004a, p. 157) postured that “the spread of health sector reform” has been utilised as “a form of cognitive globalisation” in which policies pertaining to health service provision and financing were transferred across the world. This idea drew attention to changes in health sector policy that occurred at a similar time. The arrival of ‘The Universal Declaration of Human Rights’ (UDHR) in 1948 marked a shift in the policies of international cooperation. The UN asserted that World War II had epitomised the tyranny and barbarism that could occur when people’s rights and freedoms were disregarded. Thus, in order to ensure freedom, justice and peace in the world, thirty inalienable rights felt to be the fundamental rights of all members of the human race were to be stated overtly and protected by the rule of law. As it pertained to health, Article 25 of the UDHR (1948) asserted that “everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including... medical care, and necessary social services”. In highlighting these issues, the UDHR brought health along with other issues into the foreground of conversations about international cooperation and led to the inception of subsidiaries such as the World Health Organisation (WHO). Around this time (1944) the World Bank arose, with a primary focus on the reduction of poverty. As such, they quickly became the leading financier of grants and loans to countries wishing to fuel development.

Unfortunately, as all the rights within the UDHR were aspirational, they were seen as lacking the framework and mechanisms to make them a reality. As such, the WHO’s role in changing practice was limited at this time (Lee, 2004b). Additionally, whilst the rights laid out in the UDHR were asserted as universal,

there was variation in which ones were adopted between nations as each nation's sovereignty dictated how these rights would be ascribed into national laws and thus realised by its citizens'. This meant that the changes resulting from the UDHR were variable. Conversely, the widespread acceptance of the UDHR by the UN member states created a space where individuals and organisations gained the power to challenge those nation states when they had violated its ideals. This included the work of international organisations such as Amnesty International, Anti-Slavery International, Liberty, and The Aegis Trust, to name a few.

It was 30 years later at the World Health Organisation (WHO) International Conference on Primary Health Care in Alma-Ata, Kazakhstan, that the ideals signalled in Article 25 of the UDHR were used to construct the argument that 'health for all' was in itself another human right. This argument was later adopted by the nation states present at the conference and came to be known as the Declaration of Alma-Ata (1978). The Declaration opened by urging all members of the global community to take immediate action to protect and promote the health of all people. It then defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (WHO, 1978, p. 1). Following which it highlighted that there were "gross inequalities in the health status of people particularly between the developed and developing countries" which was seen as representing a problem for the entire global community. The Declaration was considered a ground-breaking piece of work, not because it was the first to highlight the inequalities in health between HICs and LMICs, but because it was the first international declaration to outline an approach to redressing this issue, alongside outlining the role and responsibilities that world governments were to have in said approach (De Vos & Van der Stuyft, 2015). Like the UN and the establishment of other intergovernmental agencies, the declaration made explicit links between health inequality and its negative impact on social and economic development, again reiterating the importance of addressing this issue as part of the efforts to maintain world peace. The Declaration of Alma-Ata placed the New International Economic Order on the agenda of the United Nations. It represented a political renegotiation between the LMICs and HICs, as many of the developing nations had recently liberated themselves from colonialism and wished to redress the political and economic domination of the

HICs (De Vos & Van der Stuyft, 2015). The Declaration focused on primary health care, as it was felt that the broadest range of preventive and curative services could be addressed through it, thus making it the more cost-effective and integrative approach to address the health challenges in LMICs (Walley et al., 2008, p. 1001). The Declaration of Alma-Ata asserted that the disparities in health could be corrected with concerted effort from global governments by the year 2000, however this target was not achieved. Walley et al (2008, p. 1001) attributed part of the problem with the proposed primary health-care approach was that it required a clearer and more robust strategy for implementation, monitoring, and scale-up.

1.4.2 The Millennium Development Goals

The inability of member nations to meet the aims set out at Alma-Ata by the year 2000 took centre stage as the world entered the new millennium. The UN devised the Millennium Declaration, which asserted that in order for international peace, nations needed to eradicate poverty. In this respect, they took a broad remit to the concept of poverty to encompass material wealth, education, mortality, health and environmental sustainability. In order to achieve this, they proposed that nations embrace a number of values, most notably the values of equality, solidarity and shared responsibility. The UN asserted that all individuals and nations should have the opportunity to benefit from development. That the cost and responsibility for development should be shared between those who benefit the least and those who benefit the most. To this end, eight goals were proposed as a means of unifying efforts to realise these values through increasing the volume and effectiveness of aid work (see Table 1.1 below).

Table 1.1 UN Millennium Development Goals (MDG)

UN Millennium Development Goals
1. Eradicate extreme hunger and poverty
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, Malaria and other diseases
7. Ensure Environmental Sustainability

8. Global partnership for development

In light of the shortcomings of previous attempts, each goal was assigned a target and several indicators that were used to evaluate the progress made towards the corresponding goal (for a full breakdown of goals and indicators see Appendix A). These MDGs were adopted by 189 nations who committed themselves and their resources to achieving these goals by the year 2015 (HM Government, 2005). Alongside this, individual nation states continued to create individual development agendas which were supposed to feed into the overarching MDGs. Table 1.2 contains a list of UK Development Goals (DFID, 2015).

Table 1.2 UK Development Goals

UK Development Goals
1. Halving malaria related deaths in at least 10 of the world's worst affected countries
2. Supporting research to improve health in developing countries
3. Improving access to health services
4. Preventing and treating tuberculosis (TB)
5. Preventing and treating non-communicable diseases
6. Improving reproductive, maternal and new-born healthcare
7. Improving health systems
8. Preventing and treating HIV and AIDS
9. Increasing the number of people receiving immunisations
10. Preventing and treating neglected tropical diseases

1.4.3 International Health Partnerships

Within the UK, the Department for International Development (DFID) were charged with the prime responsibility of delivering on the MDGs. To achieve this aim, DFID worked jointly with several other Government offices to achieve coherence across policies. These other offices included the Treasury, the Foreign and Commonwealth Office and the Department of Trade and Industry. The UK policy framework supporting international development was laid out in the White Paper Eliminating World Poverty and with the ratification of the

International Development Act 2002. This collection of UK government departments and policies attempted to meet both national and international development agendas through three distinct methods. The first was administration of Official Development Aid (ODA) to tackle poverty, the second was reducing the debt owed by individual LMICs, and the third was building social infrastructures through the exchange of resources (Lee, 2004b). The development of social infrastructures was facilitated by the creation of International Health Partnerships (IHPs) started by Universities, NHS trusts and Charities in High Income Countries (HIC's) and health providers in Low- and Middle-Income Countries (LMIC's). Although, it should be noted that these partnerships have also existed between LMIC's (Castro, Melliush, & Lorenzo, 2014). In the UK NHS trusts have been the largest organisational group to engage in these types of partnerships (THET, 2017). Based on the findings of Lord Crisp (Crisp, 2007; DH & DFID, 2008) who stated that in order to meet the MDGs the UK would need to address the lack of trained health workers, of which there was a deficit of approximately 4.2 million, and inadequate health systems within LMICs. These partnerships framed the "high quality UK health professionals and the international reputation of the UK's health institutions" (THET, 2015) as one resource that could be exchanged with LMIC partners to increase development. In efforts to collect more robust information on the work of these partnerships, the DFID tasked the Tropical Health Education Trust with the job of evaluating and monitoring projects through the Health Partnership Scheme (HPS).

1.4.4 Critiques of Global Health

As highlighted above, there was widespread acceptance that poverty was perpetuated by health issues, and that these issues received a lack of provision within LMICs. While this stance was not disputed, what was contested was the idea that development through globalisation was the panacea for these ills. Hong (2000, p. 7) argues that development has been a form of covert neo-colonialism that continued the agenda of "imperial policies", once the former colonies gained independence. He asserted that through development, the LMICs "became tied to the world system of trade, finance and investment with" transnational corporations. He attributed the Structural Adjustment Programmes (SAPs) as a major component of this agenda. Through the SAPs. LMICs were given loans for 'development adjustment' which were only granted with the

agreement to adopt structural economic reforms and comprehensive programmes for macro-economic stabilisation as outlined by the World Bank and the International Monetary Fund. These programmes and reforms included “deregulation, privatisation, currency devaluation, social spending cuts, lower corporate taxes and the removal of foreign investment restrictions”, which eventually led to increased poverty, increased corruption and increased emigration (Hong, 2000, p. 14-15). As such, development has been framed as part of a globalisation agenda driven by financial, political, and ideological interests as opposed to being driven by the health needs of the people (De Vos & Van der Stuyft, 2015) and in so doing created more problems under the guise of helping to reduce them.

In support of the idea that globalisation has been a form of neo-colonialism, it has been argued that those nation states involved in development have largely done so with ex-colonial states (Gaillard, 1994; Hong, 2000). In the case of the UK, it is documented as committed to “concentrating” its “resources and impact in 27 countries (DFID, 2011), of which 18 were former colonies of the British Empire (Sawe, 2018). As such, the continued involvement of the UK within these countries is viewed with scepticism.

Others have argued that the globalisation of health has been driven by a neo-liberal agenda (Wodak & Meyer, 2001). Which despite having “produced unprecedented economic growth, with increased material prosperity and improved health for hundreds of millions of people”, the majority of whom reside in the global North, it has also intensified inequality”, and rendered large populations subject to ineffective health care Gill & Benatar, 2016, p. 349). Thus, the effect of globalisation of health can be conceived as both positive and negative (Lee, 2004a).

It has also been argued that despite the dominant discourse surrounding the origins of global health having stemmed from the desire to ensure the liberties and well-being of all, there is evidence of a shift in the mid 1990’s with increased “national security concerns towards ‘new’ security threats such as environmental degradation, population growth and migration, illicit criminal activity, terrorism and health risks. The latter has provoked public concern with the return of plague and pestilence” (Lee, 2004, p17). Although these concerns were linked to the increased global movement of people and goods occurring

as a result of globalisation, increased global cooperation was situated as the necessary response, as increased stability and economic growth within LMICs would decrease the motivations of people to move to HICs.

Responding to the criticisms about the way global health was constructed and carried out THET created a set of Principles of Partnership (PoP) (see Table 1.3), which all organisations engaging in the HPS would need to follow and evidence in their partnership work.

Table 1.3. THET Principles of Partnership

1. Strategic
2. Harmonised and Aligned
3. Effective and Sustainable
4. Respectful and Reciprocal
5. Organised and Accountable
6. Responsible
7. Flexible, Resourceful and Innovative
8. Committed to Joint Learning

1.5 Global Mental Health

The acknowledgment of health as a fundamental human right in the UDHR in 1948, led to discussions being opened up regarding the MH needs of people around the globe. With a growing recognition of the necessity to respond to these needs, the UN pushed the creation of the Principles for the Protection of Persons with Mental Illness and of the Improvement of Mental Health Care (United Nations, 1991). However, many HIC nation states had already begun to acknowledge the MH needs of their citizens through national laws. For example, the UK's ratification of the Mental Health Act (DOH, 1983).

As time progressed, more data was gathered on the occurrence of MH disorders around the world. From this data the WHO (2001a) later asserted that MH disorders had been estimated to affect 1 in 4 people throughout their lifetime, and accounted for approximately 12 percent of the global burden of disease (2001b). Moreover, they estimated that by 2020, MH disorders would account for 15 percent of the overall number of life years lost to ill-health. This

was framed as problematic mortality that correlates to a nation's economic production. Furthermore, as the onset of MH disorders does not lead to immediate death, but can increase the prevalence of comorbid health conditions, there is a higher cost occurring from the lack of treatment compared to the cost of treating the illness directly. This cost was estimated on figures from HICs which demonstrated that the cost difference ranged from two to six times more. Thus, in LMICs where there had been significantly less funding attributed to MH care and a higher number of sociological determinants of ill health, this cost was estimated to be greater. To corroborate this the WHO (2003) highlighted that the US spent US\$148 billion on treating MH annually, which amounted to 2.5 percent of their gross national product (GNP). The WHO then compared this to 62 percent of LMICs who spent under 1 percent of their GNP on MH. They asserted that this burden of MH was significant for the globe and thus in order to achieve the MDGs by 2015, global mental health (GMH) had to be addressed as part of the overall health agenda. To this end the WHO (2001b) made ten recommendations which are summarised in Table 1.4.

Table 1.4 WHO Recommendations for addressing Global Mental Health

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

The progress made towards addressing the global burden of MH was the centre of discussion in the 2007 special edition of the Lancet. Authors highlighted that since the World Health Report 2001, although 85 percent of the world's population was recorded as residing in LMICs, MH care remained under resourced and under staffed (Jacob et al., 2007). Thus, the sense was that the burden of MH had continued to be underestimated despite the mounting

evidence that demonstrated increased support for the scale up of interventions across all primary care settings (Chisholm et al., 2007). As well as the mounting evidence that the pharmacological and psychological treatment of MH was cost effective in LMICs. One example of this was the “interventions for depression, delivered in primary care” which proved “as cost effective as antiretroviral drugs for HIV/AIDS” (Patel et al., 2007, p. 991). This lack of progress was attributed to two distinct factors; the first being a lack of understanding about the connection between MH and other health conditions (Gold & Waghorn, 2007). The second was a lack of health policy and legislation to guide service development. As such, it was reiterated that “the call for action on treatment and prevention of mental disorders” needed to integrate mental health into public-health action” (Herrman & Swartz, 2007, p. 1195) as there can be “no health without mental health” (Prince et al., 2007). Therefore, HICs needed to renew their commitments to achieving political, financial and administrative change in order to progress towards the MDGs.

Authors also criticised the WHO for being “unable to convert their fine words into action” (Horton, 2007). Their lack of progress was attributed in part to insufficient resources given to back the aforementioned recommendations, and a failure to “build a sustainable mechanism across global and country institutions to hold itself and others accountable for its recommendations” (Horton, 2007, p. 806). These criticisms were understood as having contributed to increased use of the HPS as a vehicle through which to bring about change to global MH.

1.5.1 Critiques of Global Mental Health

As there were critiques of the use of globalisation in health, so too were there critiques of its use in MH. Cooper (2015) conceptualised two broad categories of critiques, namely biomedical and cultural, however these categories are also interlinked. One critique arose in relation to definitions of ‘mental disorder’. Summerfield asserted that psychiatry has been caught in a ontological quagmire in trying to assert that “if there are sufficient phenomena at sufficient threshold, a mental disorder is declared to exist”, yet the cluster of phenomena are not naturally occurring but socially constructed and determined to be present on the basis of minority consensus (Summerfield, 2012, p. 519). Moreover, whilst the constructions of physical health and illness generally have

agreed parameters which can be measured, understandings of health and illness in relation to MH have varied across the world, influenced largely by culture and social context (White, 1982). Additionally, within Western societies where these conceptions of MH have originated, there has been refutation of validity of the conditions from those diagnosed with them. This has highlighted that even within a culture this understanding of health and illness does not represent the entirety of lived experience (Carter, Read, Pyle, & Morrison, 2018; Longdon & Read, 2017; Read, 1997; Read, Cartwright, Gibson, Shiels, & Haslam, 2014; Read, Fosse, Moskowitz, & Perry, 2014). Yet, GMH has been seen as propagating the idea that there is a global norm for MH (Mills & Fernando, 2014), and that despite the differences between nation states, MH can be addressed with a standard approach (Patel, et. al, 2011).

Another critique challenged the validity of the assertion of the universality of MH. The WHO's (2001a) based this assertion on the idea that MH is due to biology and the physiology of the brain. Therefore, as the structures of the brain are the same across humanity it was deemed that all people were susceptible. Moreover, wrapped up with the biomedical conception of MH has been the chemical imbalance hypothesis, where MH is believed to be treatable through the addressing some underlying chemical imbalance. However, there has been evidence that this 'treatment' has not actually fulfilled this function (Fernando, 2011; Moncrieff, 2008, 2009).

Additionally, critiques have been made about the function served by globalising MH. Fernando (2014, p. 15) stated that GMH

"tends to camouflage a process whereby western ideologies and ways of thinking are being imposed in the Third World in order to structure developing countries in such a way that perpetuates western power and profits multinational corporation".

The imposition of Western reductionist ideologies has been cited as having marginalised alternative ways of understanding (Shiva, 1993), where MH is composed of multiple complex interconnected conceptions (Cooper, 2015; Mills & Fernando, 2014). In propagating the globalisation of the biomedical model of MH, GMH has created spaces for the various industries that operate within it to increase their presence and prominence within LMICs.

1.6 Summary

This chapter has demonstrated that globalisation has been used as a tool to ensure international peace and economic development. Through influencing domestic and foreign policy, globalisation brought economic gains to many nations. However, the unequal distribution of these gains was seen as a threat to the aims for which it had been chosen. Nonetheless, the successes of globalisation have led to the expansion of its use into physical health and MH, where its use was framed as having the potential to reduce inequality and increase development. Although the policies adopted to address these issues have continually fallen short of their targets, this field has continued to expand. Part of the failure has been attributed to the inability of policies to translate into practice. To allay some of these concerns, the PoP were created. However, questions arise about whether these will fall prey to the same problems as the policies or whether they will translate into practice?

2 SCOPING REVIEW

This section was written to document the scoping review carried out on the research published about IHPs. This section provides an explanation of what a scoping review is, as well as the rationale for why it was determined to be appropriate for this piece of research. Following this the method used to conduct a scoping review of the literature pertaining to IHP's will be laid out. Lastly, this section will present the results of the scoping review.

2.1 Rationale

There are various ways of reviewing the literature addressing a topic, but the ones most commonly used are narrative reviews and systematic reviews. Whilst there are agreed definition for each type of review (Cacchione, 2016), there are a number of factors which separate them from one another. Narrative reviews tend to use a focused research question to summarise the body of literature, offering critiques. Whilst the systematic review employs rigorous inclusion and exclusion criteria which thus excludes vast amounts of material from the final analysis. One example of this is where Randomised Control Trials tend to be

favoured for their rigorous control of variables. However, a scoping review was utilised for this research for two distinct reasons. Firstly, a scoping review can be used for the purposes of providing a comprehensive overview of all available literature. As this type of review does not assess the quality of the research it facilitated the inclusion of literature that would potentially have been excluded otherwise. The second rationale follows on from the first in that utilising a scoping review facilitated the identification of gaps in the existing literature.

2.2 Objective

The researcher wished to make informed decisions about the potential avenues for further research in the area of IHPs. As such, this scoping review was undertaken to achieve two broad purposes. The first was to establish a collection of the primary research which could be representative of breadth of work published about IHPs. The second, was to explore what this collection of research articles could demonstrate about the types of work published about IHPs.

The scoping review was guided by three research question:

1. What types of health problem have IHPs projects addressed?
2. What methods of analysis have been utilised in IHP research?
3. Which population groups have been the focus of IHP research?

2.3 Search Strategy

The Joanna Briggs Institute (JBI) scoping review strategy (Peters et al., 2015) was adopted as a basis from which to begin this review. This strategy was broken down into three stages. The first being to determine the relevant data stores from which to gather the data needed and the terms needed to access this data. The second stage was to determine the utility of these search terms by exploring the results garnered. The final stage involved exploring the references of the useful results to encompass more useful search terms. The details of how this strategy was employed for this review are detailed below, with a summary of the steps taken depicted in Appendix B.

2.3.1 Stage One

The first step taken was to determine the relevant journal stores and search criteria that were likely to generate the desired types of data. Searches were

conducted on CINAHL Plus, Academic Search Complete, PsychInfo, and PubMed databases with the initial search terms “Millennium development goals” AND “health partnership”. The documents retrieved employing these terms subjected to a number of inclusion criteria to increase the relevance of the results.

2.3.1.1 Inclusion Criteria: The following key words were used as part of the search strategy to draw the appropriate literature from the journal stores.

- International Partnership
- Global Partnership
- International Cooperation
- Health Partnership
- Millennium Development Goals

The first three search terms listed were chosen to help differentiate the literature from other forms of aid work, such as those which were not done in partnership, and partnership work carried out between organisations within the same country.

The second set of search terms used were “health” and the “Millennium Development Goals”. The MDG concept was felt to be a significant part of the historic socio-political landscape that gave rise to the specific type of work that this review wished to analyse. As such, it was presumed that the work carried out under this mandate would have referenced the term. As there are eight MDGs which don’t all pertain to health, utilising “health” as a search term allowed the results to be separated from those articles which did not meet this aim.

The second step involved refining the results include only those published between 2000 and 2018. As the MDGs commenced in the year 2000, this year was used as a lower limit to differentiate these pieces of work from their predecessors. Additionally, a third step was taken to only include the articles written in English given that the researcher was only fluent in English and had no funds to assist in the interpretation of literature. No restriction was placed on the type of interventions used, nor the methods of analysis taken towards the work being documented.

2.3.2 Stage Two

The results obtained from using these search terms and inclusion criteria were then screened to determine their relevance. This was done by reviewing the document titles and abstracts to separate out the literature which pertained to primary research studies from other documents such as review papers, commentaries, debates, guidelines and theoretical papers. This was done as these only those pertaining to primary research were deemed able to adequately answer the review questions.

2.3.3 Stage Three

The third stage in the JBI scoping review strategy was to explore the reference lists of the studies identified as relevant for any further relevant studies. These studies were then put through stage two to determine their relevance. Those deemed relevant were added to the results.

This stage also involved making note of the related index terms. Based on this the term “International cooperation” was incorporated into the search. As these search terms produced a small number of relevant documents the researcher included Google Scholar in the search. This search identified a number of documents that were determined to be relevant, many of which were located on the BioMed Central (BMC) database. This database was subsequently searched using the terms “Millennium Development Goals” AND “Health Partnership”, and “Millennium Development Goals” AND “International Cooperation” which yielded a higher number of relevant articles.

During the process of conducting this review the researcher was in contact with a representative from THET regarding their publications. The representative provided a list of publications that had been produced in relation to projects that they funded. The articles on this document were also searched and analysed for their relevance to the aims of this review and incorporated as appropriate. These searches were conducted during the period September 2018 – March 2019. For the purposes of replication, the steps taken to determine whether a document met the aforementioned inclusion criteria have been displayed in a decision tree (see Appendix B).

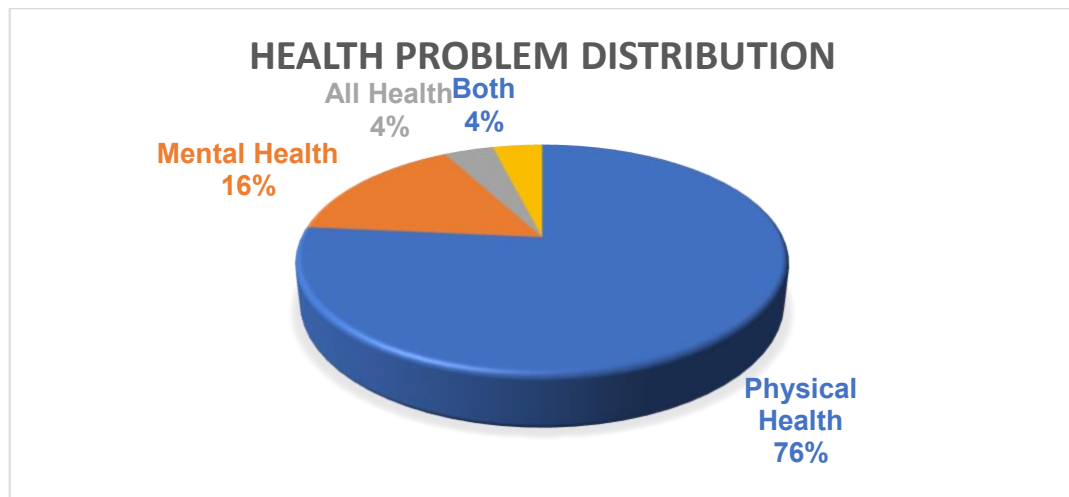
2.4 Results

The search strategy outlined above produced approximately 2000 results. Utilising the steps from the second stage these were refined down to 51 pieces of primary research relating to international partnerships addressing issues of health. These articles were then explored to determine what health problems were being addressed, which population were the focus of intervention, whether the HIC partners were based in the NHS, a University or NGO; and whether the authors represented both sides of the partnership. The following is a breakdown of what the 51 documents revealed when examined in relation to the scoping review aims (see Appendix C for a sample of the scoping review extraction table).

2.4.1 Health Problems Addressed by IHP's

Figure 1 breaks down the distribution of those 51 pieces of research into three main categories, those that addressed Physical Health (PH) problems, those that addressed Mental Health (MH) problems, and those that addressed both MH and PH problems. 39 (76 percent) of the projects addressed PH problems. There was a wide spread of health problems addressed, the most common problems pertained to sexual health (6 articles), followed by Epilepsy and maternal health (each with 4 articles). 8 (16 percent) of the project included addressed issues of MH, with the most common focus on PTSD (3 articles). 2 (4 percent) of the projects included covered both PH and MH. The two articles found explored comorbidities between pregnancy and MH, and epilepsy and depression. There were 2 projects (4 percent) which did not identify a health problem, but focused more on organisational groups.

Figure 1. Scoping Review Health Problem Distribution



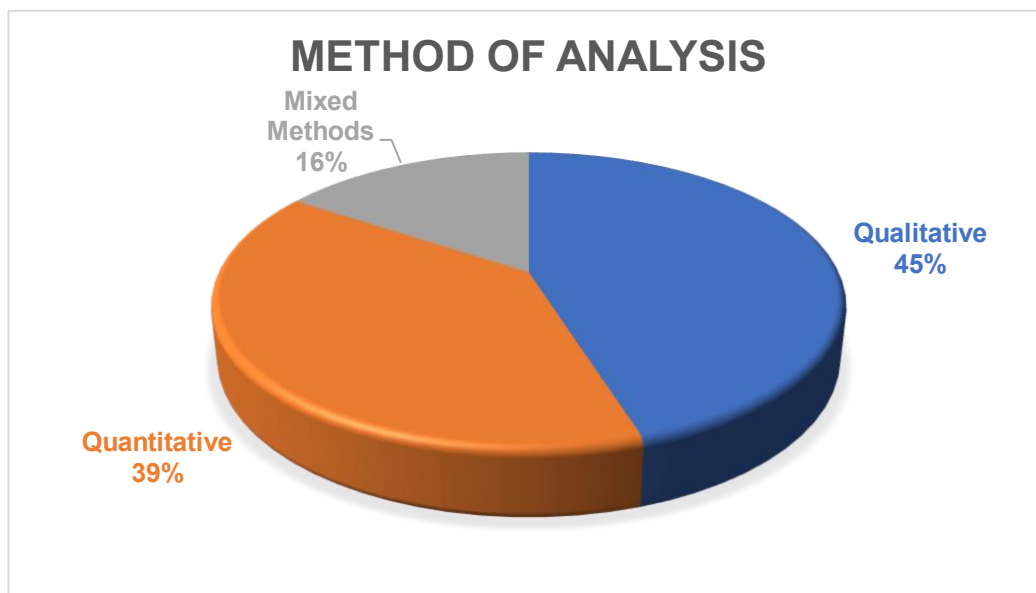
As the movement for Global Health was set up to focus on Physical Health issues it is not surprising that Mental Health issues have not featured heavily in the work carried out. However, the results of this review indicate that there has been an increase in the focus of projects addressing Mental Health. This increase coincided with the UK Governments acknowledgment of the claims made by Prince et al (2007) that there could be 'no health without Mental Health' (HM Government, 2012). The small number of projects which addressed both MH and PH might be interpreted as speaking to low levels of integration between the two. In UK, PH services do not all have integrated MH professionals, and MH services do not often have staff with highly specialised PH skills. As such it is unlikely that a single service would be able to attend to both health issues. Thus, the lack of integration of MH and PH could have reflected the status quo of UK health services. However, this could also have represented a lack of interest in the LMIC partners towards addressing MH. Nonetheless, at the present time there can be little more than speculation as there has been very little written about the process and/or dialogues between partners that determined which health problems were addressed. This in itself may be due to some of the difficulties of engaging in this type of work; as Storeng & Palmer (2019) wrote about the ways in which partner organisation can censor, influence and suppress what is published about the work of international partnerships.

2.4.2 Methods of Analysis

The 51 documents were further categorised on the basis of the primary methods of analysis they utilised (depicted in Figure 2). This showed that 23 (45 percent) projects employed qualitative analysis. This group included document

analysis, interviews, observations and focus groups, with interviews representing 48 percent of the data. 20 (39 percent) of the articles utilised quantitative analysis and 8 (16 percent) utilised both.

Figure 2. Scoping Review Method of Analysis Distribution



The methods of analysis were analysed in relation to the health problems they addressed. Of the 39 projects which addressed PH problems the most prevalent methods of analysis were quantitative measures (35 percent), followed by and interviews (23 percent). Of the 8 projects which addressed Mental Health problems, the most prevalent methods of analysis were quantitative measures (50 percent). 37 percent of the articles used qualitative methods of analysis, of which interviews was most commonly utilised (26 percent). The least used methods of analysis were observation and document analysis which had been used in no published IHP research.

This review highlighted a number of gaps in the literature. The first was that very little research has utilised a mixed qualitative and quantitative methodology. With almost equal occurrence of the two types of data, this could be demonstrating a proclivity to explore either statistical change or experiential change. This split has meant that there are large portions of knowledge and learning about the work of IHPs which has not been formally captured.

The second gap was discovered when the methods of analysis utilised were explored in relation to the health problems addressed. This analysis highlighted that very few PH projects had utilised focus groups as a means of assessing

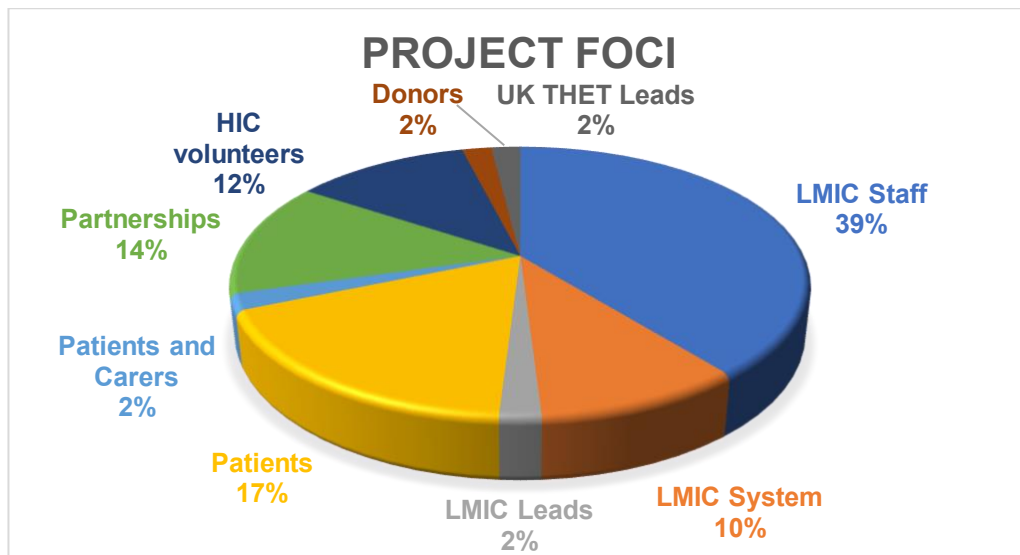
impact. This could convey that there is less interest in the group experience of the difficulties being addressed. Additionally, no MH projects had utilised document analysis, which can capture the various ways of communicating around an issue and how they relate to various forums in which communication takes place.

The over and under representation of different methods, conveyed something about what is held to be of importance in the work of IHPs. The high representation of quantitative measures aligns with the UK government focus on demonstrating impact through numbers of staff trained and numbers of people seen. Whilst the under representation of other qualitative measures signalled a lack of interest in the personal experience beyond what is directly asked, and what lies beyond the immediate impact to services. These issues were interpreted as connected to the Hong's (2000) criticism of global health being less concerned with the needs and experiences of the populations they interact with.

2.4.3 Foci of Projects

In addition to analysing the 51 documents in relation to the health problem addressed and the method of analysis used, the documents were analysed in relation to their focus. As IHPs have focused on knowledge transfer the foci were defined by the population group who were targeted. Articles which stood alone in their focus were named using the distinct category title. Conversely, where several different terms were used to refer to one distinct group, they were categorised according to the broadest but most distinct features. For example, 'LMIC Staff' was a category that contained Community Health Workers, Project Workers, and Doctors, all of which were seen as being of a distinct organisation position which was different from 'LMIC Service Leads'. 'Partnership' was used to categorise work that specifically focused on the relationship between the different organisations involved in the partnership. This relationship was seen as distinct from the relationship between the project partners and the 'Donors' who fund their research. 'LMIC Systems' referred to projects which addressed issues of productivity, efficiency and safety. Figure 3 depicts the different categories of project foci and the percentage of how they were represented within the review.

Figure 3. Distribution of Project Foci.



20 Projects focused on 'LMIC Staff', these projects represented the most prevalent focus for IHP work (39 percent). This was more than double the amount of the next largest group of projects which focused on issues relating to 'Patients' (17 percent).

When the documents foci were analysed in relation to the PH problems addressed, the most prevalent focus was on 'LMIC staff' (31 percent), closely followed by 'Patients' (21 percent). The least researched group was the 'UK THET Leads' who to date have not been the focus of Physical Health IHP projects.

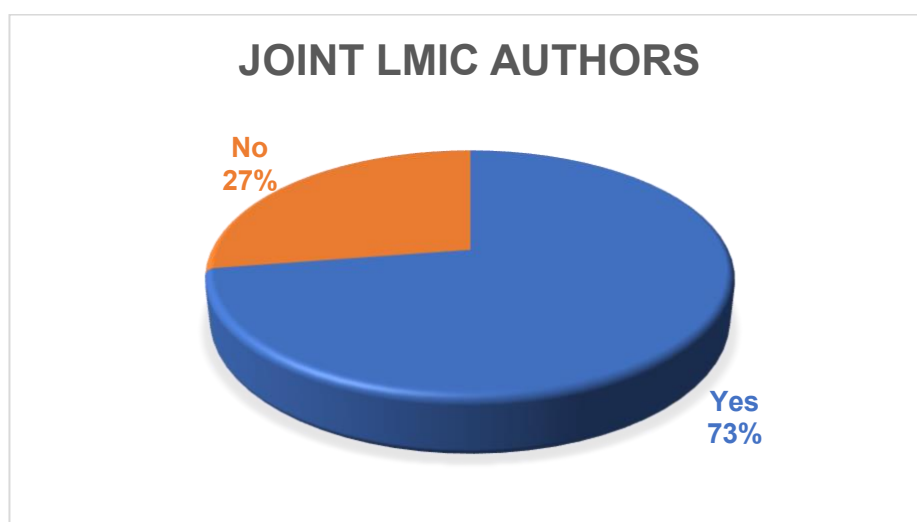
This process of analysis was repeated to explore the document foci of those projects which addressed MH problems. The analysis revealed that there was a narrow distribution of project foci. The most researched group were also 'LMIC Staff' (75 percent), followed by 'HIC Volunteers'. There were several groups which had not been researched at all, namely 'Donors', 'LMIC Leads', 'LMIC Systems', 'Carers' and 'UK THET Leads'.

2.4.4 Joint Authorship

As the literature around health partnerships documented concerns that accounts of work completed were being disseminated by HIC partners without LMIC contribution the articles gathered were explored to identify whether this concern was born out by this new derivation of health partnership. Figure 4 depicts the percentage of articles reviewed which had LMIC staff as co-authors. The results indicated higher number of joint authorship. This could signal a shift

in the power relations between HIC and LMIC practitioners, away from the concerns of neo-colonialism towards more equitable relationships.

Figure 4. Percentage of Articles Demonstrating Joint Authorship



2.5 Discussion of Scoping Review

This scoping review highlighted a number of trends in the literature pertaining to the primary research conducted by IHPs. The number of projects published was surprising as THET boasts that 249 projects delivered by some 180 partnerships (THET, 2017). As such, the inclusion of only 51 accounts of primary research demonstrated that the trend for publishing might be less towards primary research. Without further scoping reviews to analyse the other data types this will remain unclear. What is well documented is the way that negative results have routinely gone unpublished (Dwan, Gamble, Williamson, & Kirkham, 2013; Ferguson & Heene, 2012; Laws, 2013; Vasilev, 2013). Additionally, the fact that so few of the published projects (27) have met the criteria for inclusion in reviews of effectiveness (Kelly, Doyle, Weakliam, & Schönemann, 2015), combined with the significant political, reputational and financial consequences for not achieving the ambitious targets set for IHP work (Rajkotia, 2018). These figures could signal the presence of potential problems in achieving targets within IHP work.

The second trend this review highlighted was that the majority of projects published have focused on the LMIC Staff. With very few projects evaluating their work between project partners and the funders (Government and Donors), Carers, LMIC Service Leads and UK THET Leads. This could have been

perceived as the logical focus given the impetus for projects to have achieved sustainability alongside the great need for workforce development. However, this activity feeds into the discourse that LMIC workforce development is the main way to achieve sustainability.

Additionally, whilst 15 percent of the research captured in this review focused on 'Partnership', this only accounted for the relationships between HIC and LMIC partners. The literature indicated that no other relationships were explored. Thus, there is a gap in the literature for further exploration of the various relationships that are encompassed within and impacted by IHPs.

2.6 Implication for This Review

As this scoping review had been carried out as part of a larger piece of academic work, the trends and gaps were used to inform the potential directions of further research. As mentioned previously, few projects focused on the relationships between the different groups involved in IHPs. This influenced the researcher to explore what can be known about the relationship between the IHP partners and their UK funders. Secondly, as the researcher was coming from a MH practitioner standpoint the focus of the IHPs were limited to those which addressed MH related problems. Lastly, it was determined that the discussion on what can be known about IHPs could be widened through conducting document analysis of the reports produced from these partnerships. This review demonstrated that this methodology had been under-utilised by those projects attempting to address MH concerns. Additionally, the reports represented a distinct form of discourse between those engaged in the work and those responsible for funding it. Thus, the analysis these documents would contribute to an understanding of what the funders deemed of importance, as well as the discursive practices used by UK partners to talk about the work they had carried out. Moreover, those factors could be useful in understanding the active function of these documents.

3 EPISTEMOLOGY AND METHODOLOGY

This section is deigned to orientate the reader to the aims of this research. This will entail an introduction to the ontological and epistemological positions taken

towards the research and demonstrate how this has informed the research design. This section will also outline the procedures taken in data sampling, collection and analysis.

3.1 Research Aims

As a means of understanding whether the ways in which health professionals talk about their work is connected with the processes which surround their work; this research has been constructed to evaluate the different ways that health professionals talk about the Mental Health projects carried out in the UK Health Partnerships Scheme.

This research was designed to answer the following questions:

1. What are the discursive devices used in communicating the work conducted in IHP's?
2. Do the discursive devices used by health professionals embody principles of partnership?
3. Does the way in which health professionals talk about their work connect with the processes which surround their work?

3.2 Ontological and Epistemological Position

To understand the focus and design of this research, it is important to grasp the bases on which the design rests, namely ontology and epistemology. The term ontology refers to the study of what is considered 'real' within our social world, and as such, is concerned with the kinds of things that we can know about it (Schwandt, 2007; Snape & Spencer, 2003). The term epistemology refers to "the study of the nature of knowledge", and how this knowledge can be acquired (Schwandt, 2007; Snape & Spencer, 2003).

3.2.1 Ontological Position

This research has been situated in a realist ontology. Realism posits that there is an external reality, which exists independently of people's beliefs and understandings. This means that IHP's have a material reality and that therefore something significant can be known about this. There are various other ontological stances, which would guide the research in a different direction, and these can be grouped together under the general categories of Materialism and Idealism. Materialism is similar to Realism in that it also asserts that a real world

exists externally to the mind of the individual. However, it makes a distinction between the material features and the non-tangible features, where the former is considered to be a part of reality while the latter is merely a by-product of the reality that has no power in itself to shape the material world. If applied to this area of research, it would effectively mean that IHP's would be knowable simply by the economic relationships they embody (i.e. the transition of money from one party to another), or the physical resources that make up these relationships. This could mean that the non-tangible features of exchange such as whether a partnership feels equitable, respectful or reciprocal would be of no consequence, as these things have no bearing on reality. Idealism asserts that "reality is only knowable through the human mind and through socially constructed meanings" (Snape & Spencer, 2003). As such, there is thought to be no distinct shared reality, but various constructions of reality which can be seen as relative. Adopting such a position may allow for the examination of the different socially constructed representations of IHP's, however there would be no benchmark by which to evaluate these representations and their potential impact on social realities (Willig, 2016).

3.2.2 Epistemological Position

Epistemology is concerned with the ways in which it is possible for us to know the social world, and thus draws attention to the basis on which these claims are made. This research is situated in a Critical Realist (CR) epistemology. CR takes the Realist stance that there is a reality that can be known separately to mental processes, and goes beyond this to assert that reality can only be known through mental processes, and that these processes are socially constructed. This position would thus allow for the acknowledgment that IHP's are part of reality, but draw attention to the various representations of IHP's in order to derive any meaning from their existence. As the researcher is interested in the various representations of IHP's and these representations are socially constructed, it could be argued that a Social Constructionist (SC) epistemology could also be utilised. A SC epistemology could support the research to understand the relationship between the discursive practices and the material practices (Riley, 2002), but would take the stance that the material world and its practices are reducible to discourse, and as such would disregard the contribution of non/extra-discursive elements. For this reason, the research has taken a CR epistemological stance, as it acknowledges the meaning made

through interactions, but also acknowledges the importance of paying attention to the extra-discursive elements and their potential impact on meaning. For the purposes of this research, extra-discursive elements can be thought of as the elements of reality that exist outside of the individual which structure their discourses, these include embodiments, materiality and institutions (Sims-Schouten, Riley, & Willig, 2007, p. 102).

3.3 Method

3.3.1 Data Type - Documents

Documents can represent a distinct type of speech that can be considered to be laden with social practice. This can constitute a 'reality' that exists independently of the writer who has produced the document and the researcher attempting to draw meaning from the document. As a source of data, documents contained multiple distinct advantages. The methodological advantages to using documents included the idea that documents are 'unobtrusive' and 'non-reactive'. Compared with observation as a data source, documents and their content are unaffected by the presence of the researcher or the processes of research. This makes documents a stable data source, as researchers are more able to replicate the process of obtaining and analysing them compared to other methods. Another methodological advantage resided in documents being a form of 'naturally occurring' data. As the researcher simply gathers accounts that occurred within their context, they are not subject to the methodological critique of having inserted themselves into the context in which the data was created.

This research has focused explicitly on reports as a type of document through which to analyse the work of IHP's. The data within the reports captured a type of relationship that has been underrepresented in this field of research, namely the relationship between the resource rich UK partners and their potentially powerful funders. This relationship represented a distinct theoretical advantage over other types of data in their ability to speak to the use of social power. It is said that the "patterns of discourse control and access are... closely associated with social power" (van Dijk, 1995, p. 20). Van Dijk explains that ordinary people generally only have access and control over the informal genres of discourse which are commonly produced in everyday communication. While the elites, such as those in institutions, generally have access and control over the

production of a plethora of both informal and formal discourses. As the relationship between UK partners and funders was subject to formalised and routine contact through reporting, the analysis of the reports provided a methodological medium through which the presence of social power in IHP's was explored. For the purposes of this research, the funding/overseeing body shall be referred to as the document "creators" and those completing the reports as the "contributors".

3.3.2 Data Selection

As described in the introduction, in the UK context IHP's are funded by the UK Government Department for International Development (DFID). DFID devolved responsibility for assessing, monitoring and evaluating the work done in IHP's to the Tropical Health Education Trust (THET). This funding allowed for the creation of over 170 programmes, which were managed by over 130 different partnership arrangements. The researcher limited the focus of the projects to those that were designed to address issues of mental health. This decision was made for several reasons. Firstly, whilst Clinical Psychology (CP) also has a role in physical health settings, this in many ways can be seen as an emerging practice when compared to the longer history of CP being embedded within mental health services. Furthermore, the focus of CP work in health settings has focused on addressing the mental and emotional sequelae of the underlying physical health condition. Secondly, the debate about the ethical implications of exporting models of care have been less fraught in physical health than mental health. As previously stated, part of the debate in relation to mental health has been about the ethical implications of sharing concepts of best care for concepts of disorder and disease that have been constructed out of distinct epistemological and philosophical worldviews that are not inherently present within LMIC's (Cox & Webb, 2015; Mills & Fernando, 2014; Summerfield, 2008, 2012).

As THET were responsible for overseeing the funding allocation and evaluation of the HPS their website was explored for information about the NHS Trusts who had completed projects. The website contained a database of all 249 completed projects that could be filtered by health theme. When the scope of the projects was narrowed to focus on Mental Health, 16 projects remained.

From this list, those not completed by NHS Trusts were excluded from the sample, which left 12 projects by 5 NHS Trusts

For each NHS Trust that remained, their websites were searched for the appropriate contact information. Under UK law, NHS Trusts are recognised as “public authorities” and thus the documents they produce are subject to public scrutiny (Freedom of Information Act 2000). For this reason, the documents were solicited via Freedom of Information (FOI) requests, which in accordance with the Act were made in writing via email (see Appendix D). As the process differed between Trusts, emails were sent to either an identified person or to the Trust FOI departments. The NHS Trusts then had twenty working days within which to respond to the request.

Of the five NHS Trusts contacted all responded to the FOI request. Several of the trusts denied knowledge of having taken part in the HPS, but were more forthcoming once provided with evidence to where they were named explicitly by THET. Each of the trusts contacted provided documents produced as part of their project work. Unfortunately, a number of the trusts did not provide the funding reports for all the projects completed. Table 3 outlines the number of projects completed by each trust and the corresponding number of reports provided in response to the FOI requests.

Table 3 NHS Trust responses to FOI request

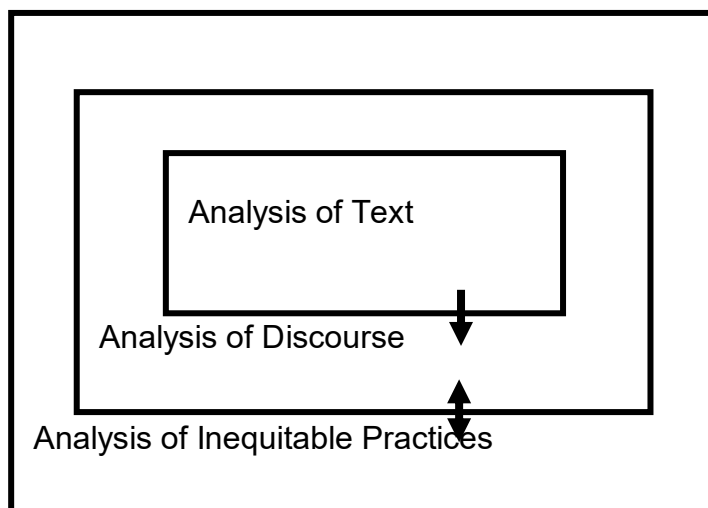
Number of projects completed	Number of documents provided	Number of formal reports provided from same trust
2	2	2
4	4	2
2	5	0
1	4	1
2	8	1

Of the documents collected, only those that were constructed as part of the formal THET project evaluation were analysed. While the other documents were believed to capture information about the projects, as they were not part of the formal evaluation process, they were deemed as unable to contribute directly to the relationship between the UK partners and their funders.

3.3.3 Data Analysis

The analysis of documents requires a systematic procedure through which text can be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge (Bowen, 2009). Given the CR epistemological approach, this research has utilised Critical Discourse Analysis (CDA) as the means of analysing the aforementioned documents. CDA is conceptualised as an approach that can be applied to focus on micro-linguistic features, macro-linguistic features, textual, discursive, and contextual features (Wodak, 2001). Diagram 1 below depicts how CDA was used to move between the various features of the text.

Diagram 1: Graphic Depiction of CDA process



CDA can also be used to explore concepts from various (philosophical, sociological or historical) perspectives, utilising a number of different methods of analysis. Thus, the researcher had the freedom to determine which techniques would best meet the research aims (Meyer, 2001). In this manner this research has utilised a number of discursive techniques to analyse the data produced by IHP's. After identifying the reports as the desired source of data, the reports were appraised, and their data synthesised. In keeping with discursive traditions, the synthesis of the data comprised of three phases, a structural analysis, a discursive analysis and a critical analysis phase. It is to be noted that whilst the phases are presented linearly, they are not to be considered discrete, but connected in a triangular manner where the researcher travelled backwards and forwards between phases throughout the analytical process.

3.3.3.1 Structural Analysis: The structural analysis orientated the researcher to the style and form used in the document. In analysing the structure of the documents, attention was given to:

- what the documents asked of those who contribute to them,
- who was being asked to contribute responses,
- the various ways in which contributors were asked to respond.

Each of the aforementioned were believed to be connected to ideas of production and function (Prior, 2003). These elements of a document can be understood as providing structure to the episodes of social interaction. These structures make visible the elements of the interaction that the creators of the document believe are knowable about the interactions. Moreover, Prior (2003) argues that the very order of these structures can be analysed for connections to forms of social order. To make the distinction between which structures where of importance, the researcher drew on the ideas of O'Leary (2014) who highlighted that the analysis of documents involves the exploration of the 'written evidence' (the intended meaning overtly imparted to the reader) and the 'unintended evidence' (the other meanings that can be gleaned from the documents). One example of unintended evidence would be observed in the types of data that are and are not requested of the authors, as the presence, absence and prominence of different types of data signal what information is held to be of importance and consequently what is not. Another way of ascertaining unintended evidence would be as Fairclough (1992) outlined, through the analysis of the data to identify practices of production, distribution and consumption. These may not be overtly stated, but can be used to influence responses. The researcher adopted the position that these structures signal power relations where one party is able to impose frameworks for meaning making on other parties, thus restricting and focusing what can be expressed.

3.3.3.2 Discursive Analysis: In the reading phase the researcher submits the data to a thorough examination. The researcher adopted the Discursive Action Model (DAM) proposed by Edwards and Potter (1992), in which text are regarded as forms of social action. Edwards and Potter assert that text construct accounts of what has happened. However, these constructions are not seen as neutral, as the contributor has a stake or interest in what is being

conveyed, and as such will employ a number of rhetorical techniques to construct their account as factual.

Edwards and Potter (1992,) identified a number of rhetorical devices that can be employed in text (although they recognise that this is not an exhaustive list):

- “Category entitlements”- the expectation that people in particular positions are holders of knowledge, and as such the category the speaker falls into can provide veracity to what they contribute to particular documents.
- “Vivid description”- where the contributor provides rich concrete details to create an impression of an experience.
- “Narrative”; where rich details are provided in a causal sequence which increases the plausibility of the actions taken as they are constructed as inevitable or necessary.
- “Systematic vagueness”- the inverse of vivid description, where the account provided lacks the depth of detail that might leave them susceptible to being refuted or undermined.
- “Empiricist accounting”- a style of discourse characteristic of the sciences, where phenomena are objectified as agents. This positioning either deletes the presence of the producer or treats them as a passive recipient of the phenomena.
- “Rhetoric of argument”- the way that accounts are constructed as arguments that follow a logical or syllogistic form. They impress upon the reader that the decision made was the most appropriate outcome by focusing on the external factors which make up the argument, thus minimising the likelihood of the actions being attributed to the internal inferences of the producer.
- “Extreme case formulation”- where events are represented using extreme examples which serve to make the message connected to the example more effective.
- “Consensus and corroboration”- where the plausibility of an account is increased by noting the different parties who agreed, with special significance given to the independent parties.
- “Lists and contrasts”- where information is organised to increase its rhetorical effectiveness. Of particular mention, is the three-part list

which is said to convey a sense that what is being said is complete or representative.

DAM was used to analyse the text, in order to make transparent the ways in which rhetorical devices were actively used in the construction of discourses. Discourses being ways of talking, which position different parties and to orientate the hearer towards particular understandings of those involved.

3.3.3.3 Critical Analysis: *At this phase of analysis, the researcher employed more “critical” discursive practices, as these denote an explicit focus on making visible the ways in which things are interconnected. In particular the relationship between discursive and non-discursive practices. The term non-discursive refers to “material structures that exist independently of our understanding of them” (Sims-Schouten et al., 2007, p. 103). CRs like Bhaskar recognised that while social practices are concept-dependent, they are not merely conceptual, but always have a material dimension to them. Thus, in order to truly understand them, attention must be paid to their non-discursive elements. In this context, non-discursive elements could be the way in which powerful organisations and governments control the access to resources (Cromby & Nightingale, 1999). Wodak (2001, p. 2) described CDA as “fundamentally concerned with analysing opaque as well as transparent structural relationships... as manifested in language”. For this reason, CDA seeks to critically investigate how inequality is “expressed, signalled, constituted, legitimised” in discourse (Wodak, 2001, p. 2). Central to CDA are the concepts of “power”, “ideology” and “history”.*

Power has been conceptualised as the ability of a thing possessed by individuals or groups to determine how others are able to access resources. This power is often gained through the acquisition of resources, of which there is often limited supply and high demand. Given the imbalance in supply and demand, the individuals of groups with the supply become entitled to redefine the conceptual boundaries of the resource, as well as the material practices that govern its dispersal. Moreover, power is intrinsically linked to knowledge, and consequently can be understood “as the ability to position particular understandings as real or legitimate” (Sims-Schouten et al., 2007, p.107). Whilst power can be possessed by individuals, its ties to resources can only be expressed in relationship with others. As documents are rarely ever produced

by one person, the text within them can be an important source through which power can be observed. Power is not derived from language, but it's interconnected relationship with language can be observed in text in several ways. The expressions of language have been used to communicate power, to index power, and to depict contentions over power. Additionally, power is also communicated in language through the decisions about what is not said. The differences in the text illustrate differing discourses and ideologies which are contending with each other for dominance. Consequently, part of the aim of CDA is to examine the "intertextuality and recontextualization of competing discourses" (Wodak, 2001, p.11). CDA is not only concerned with the ways in which power is signalled within text, but also the who controls the occasions in which the texts are created.

Thompson (1990) described ideology as the ways in which meaning is constructed and conveyed in symbolic forms. It is concerned with the "processes within which, and by means of which, these symbolic forms circulate in the social world" (Wodak, 2001, p.10). These means and processes are seen as essential to how relations of power are established and then maintained. CDA's focus on ideology is an endeavour to understand the social contexts within which symbolic forms are utilised and exploited. In so doing, it can determine whether and how they connect with relationships of power.

All discourses are seen as being situated in time and space. As such CDA attempts to take account of the context in which the discourses were created, and in so doing produces understanding about the ways in which the discourses have been interpreted. This serves the purpose of exposing how power has been used to legitimise certain ideologies. CDA provides a means through which it is possible to analyse presence of power from above and the possibilities of those in unequal power relationships to challenge said power.

This research employed a CDA approach to analysing the reports produced by the IHP's to the THET. CDA does not ascribe to a prescribed process of analysis, but asserts that the researcher utilised the techniques of analysis which are more suited to the research aims. As such, the researcher has drawn on a number of techniques utilised in various discursive traditions to analyse the contents of these reports and connect said content with the wider social context as a means of demonstrating what these documents can do.

4 RESULTS

4.1 Structural Analysis

As stated in the methodology section, the project reports were collected because they were deemed to be a useful source of data for understanding IHP work. Table 4.1 set out some of the defining features of each of the reports analysed.

Table 4.1 - Descriptive table for Report documents

Document	A	B	C	D	E
LMIC Continent	Africa	Africa	Africa	Africa	Africa
Subject of concern	Substance Misuse	CAMHS	Recovery	Mental Health information	Management of violence and aggression
Target Population	Service Users	Health Professionals	Service Users	Community members	Health professionals
Populations engaged	Health Professionals	LMIC University	Health Professionals	Health professionals	Service Users
Method of intervention	Staff training	Professional education	Staff training	Staff training	Staff training

These documents were also deemed to be useful in understanding the communication that took place between the IHPs and THET. THET was held as occupying a position of power over the IHPs as they were responsible for authorising, funding and evaluating the projects completed by the partnerships. The reporting template used represented a reification of this power, as it contained the data by which THET made judgements about the work of each project. Within the reporting template, both the questions asked, and the spaces

constructed for them to be answered were deemed to be ‘structures’ which imposed boundaries on what could be communicated about the projects in question. As such, they were analysed before the individual responses of each project to explore their potential impact on the communication itself.

For the purposes of clarity those responsible for providing the data in the reports were henceforth referred to as the ‘authors’. Whilst those who were responsible for evaluating the data on the projects were henceforth identified as the ‘evaluators’. Additionally, to view the entire report template please see Appendix E.

The guidance provided at the very beginning of the document was interpreted as written evidence of the agendas the evaluators chose to convey.

“This reporting template provides you with the opportunity to summarise and reflect on recent achievements, partnership development and lessons learnt. As this is your final report, we have also included sections covering the overall progress of your project since its inception and the sustainability of results as a chance to reflect more deeply on some of the overall impact of your partnership work and to celebrate your achievements.”

From this note it was surmised that the evaluators were interested in the ‘achievements’ of the project, the ‘partnership’s development’, the ‘lessons learnt’, the ‘sustainability’ the progress, and the ‘impact’ of the achievements. This interpretation was supported by the way in which the main document sections (see Table 4.2) were demarcated as pertaining to each of the aforementioned agendas.

Table 4.2 – Report Template Main Sections

Section 1 - Project team
Section 2 - Project activities
Section 3 - Project results
Section 4 - Partnership development
Section 5 - Lessons learnt
Section 6 - THET performance
Section 7 - Finances

Section 8 - Other sources of information about your partnership and project.
--

4.1.1 Production

The structure of the report was conceptualised as having facilitated the production of three types of data, descriptive, evaluative, and reflective. Although the latter two contain descriptions they are seen as doing something distinct and as such have been analysed for their independent contribution to the structure of the document. The sections below outline how the evaluators used each type of data to elicit information from the authors, some of the limitations placed on what could be learnt as a result and examples of author responses that corroborated these interpretations.

4.1.1.1 Descriptive: There were a number of report template sections which requested only descriptive data (as laid out in Table 4.3).

Table 4.3 – Report Template Descriptive Sections

Report Template Section	Section Title
Section 1	Project team
Section 2.1	Progress against activity plan
Section 3.6	Volunteer and Training Numbers
Section 4.4	The future of the partnership
Section 8	Other sources of information about your partnership and project

The progress against activity plan section of the report template invited authors to identify the occurrence of activities. This was done using a table which allowed the authors to indicate when in the project lifespan the activity occurred. The key at the top of the table indicated that authors were to use symbols to denote changes in project activity. It appeared that the authors had previously identified predictions for completion of each indicator, which was identified with the symbol 'X' placed into the table. The authors were required to indicate which activities had been met with the symbol 'Y' and which activities were cancelled with the symbol 'C'. This method of data collection reinforced ideas of activities as discrete tasks, which could have multiple occurrences, as well as

signalling that activity would be evaluated against their initial plans. In making explicit that the evaluator of the report was interested in when and how often activities occurred in comparison to initial plans, it could be signalling a form of accountability where authors can be blamed for the failure to achieve activities. Conversely, framing the activities in this manner also had limitations for what could have been gained from this section of the reports. In communicating activity as discrete tasks, the complexity of the task and the difficulties in achieving them were diminished. This was taken as an indication that the evaluators were more concerned with task completion than the details of how tasks were carried out.

Returning to the Project Activity section; in addition to the use of 'X' to denote predicted activity completion several projects completed this section of the report using symbols not outlined by the evaluators (namely 'N' and 'E'). Unfortunately, as there was no reference to what these symbols meant it was not possible to draw direct meaning from them. However, their presence reinforced the idea that these activities were laid out in a document that predated this report (potentially the initial grant application document).

The Volunteer and Training Numbers section of the report template asked authors to document the number of health workers who participated in their training projects. The data was collected using a series of tables to differentiate between the different cadres of professionals trained, locality of employment, gender and pay scale. This differentiation in gender was viewed as an effort to capture how the work aligned with Goal 3 of the MDGs to promote gender equality and empower women. Lastly, this section of the report requested that the authors identify the pay scale bandings for each of the HIC volunteers who took part in the projects. These figures were then broken down to demonstrate the number of days volunteered in the HIC and the LMIC. These figures were seen as relating to the desire to cost the input provided by the HIC organisations, potentially feeding into the arguments about how cost-effective this way of working is given the limited number of HIC staff volunteering their time. Each of these pieces of information were deemed important by the researcher as these figures were later used by the evaluators and the HIC government partners they represent as markers of achievement and impact (THET, 2017), with the higher numbers of staff trained and higher numbers of

days volunteered directly representing more achievement. It was also felt that the exclusive use of quantitative data in these sections meant that the evaluators missed an opportunity to gather information on the potential impact of different team compositions on project achievements. However, whilst gathering qualitative data for these indicators would have increased the complexity of the evaluation, they could have contributed data which could not have been adequately represented with numbers alone.

4.1.1.2 Evaluative: The term ‘evaluative’ was used to describe the text that required the authors to make a judgement about aspects of their project in relation to a goal, or a predefined scale. The sub-sections of the report template which requested evaluative data were documented in Table 4.4

Table 4.4 – Evaluative Report Template Sections

Report Template Section	Section Title
Section 3.1*	Progress against indicators
Section 3.3*	Sustainability of results
Section 3.6.3**	Volunteer professional development
Section 4.1	Partnership development goals
Section 6**	THET’s Performance

Section 3.1 of the report template required authors to evaluate the progress of their project. The authors were asked to identify their project indicators, next to which they were required to provide numerical data for the baseline figure taken for each indicator at the beginning of their project, the target for change identified from their project application, and the cumulative data towards achieving this target. Following this, the authors were required to provide a mixture of evaluative and reflective data on the progress made towards individual outcomes, and finally evaluative data on their processes of data collection, management and interpretation. The tabular format and mixture of qualitative and quantitative spaces within this report section were understood as an attempt to convey the need for transparency in reporting.

Similarly, the ‘Sustainability of Results’ section of the report template utilised a tabular format to capture both qualitative and quantitative data. Each row was used to capture data for individual project indicators. However, as this section

was specifically designed to capture data on how the outcomes of the project would be sustained over time, this section utilised a 5-point Likert scale ranging from “1 (= not sustainable) to 5 (= fully sustainable)” for the rating of each project outcome. This was followed by a free text space within which the authors could evaluate their sustainability progress. The evaluators framed the scope of the evaluation by asking authors to provide evidence of sustainability and any barriers identified”. The format of the aforementioned sections was understood as having demonstrated a clear intention on the part of the evaluators to collect a robust mix of data that pertained to project achievement and the sustainability of the progress achieved. However, it should be noted that in using the Likert scale to evaluate project work in this way the evaluators attempted to transform complex procedures into more simplistic quantitative data which more easily lent itself generalisations in reporting. In doing this the evaluators could be seen as creating distance between themselves and the finer details of the project work. Additionally, the process of sustainability rating utilised subjective interpretation of the situations surrounding project outcomes and goals. This became of increased importance when questions about who was providing the rating are called into question, and were covered in other sections of this analysis.

Table 4.4 contained sections of the report template differentiated with a double asterisk. These two sections (‘Volunteer Professional Development’ and ‘THET’s Performance’ sections) of the report template contained links to electronic surveys outside of the document. Although each survey was explored, as they sat outside of the main document they have been excluded from detailed discussion.

4.1.1.3 Reflective: The document contained multiple sections which had been structured towards eliciting reflective data (See Table 4.5). Following the ‘Sustainability of Results’ section, where authors were asked to rate and evaluate the sustainability of the progress made for each project indicator. Authors were asked to reflect on what they had learnt in the process of trying to achieve sustainability for the identified project indicators. This was perceived as being an open and non-directive way to engage authors in thinking about their work, which differed from how they were asked to reflect on their work in a similar space offered in the ‘Progress Against Indicators’ section. In this section

authors were directly asked to reflect on the “challenges faced in collecting and managing” data. Thus, the open and neutral phrasing of the question was understood as having reflected an implicit assumption that there was potential learning that would be occluded by having been too directive. This was seen as connected to the historic criticisms that health partnerships lacked sustainability.

Table 4.5 – Reflective Report Template Sections

Report Template Section	Section Title
Section 2.2,	Notes on incomplete activities
Section 2.3	Notes on unforeseen / unplanned activities
Section 3.1	Progress against indicators
Section 3.2.1	Other project achievements within the reporting period
Section 3.2.2	Overview of project highlights
Section 3.3	Sustainability of results
Section 3.4	Methodology and evaluation review
Section 3.5	Project beneficiaries
Section 4.1	Partnership development goals
Section 4.2	Other changes to the partnership
Section 4.3	Partnership overview
Section 5	Lessons Learnt
Section 7	Finances

The first section of the document in which the authors were permitted to comment was used to identify the individuals who have contributed to the report. All of the reports named senior members of the HIC and LMIC ends of the partnership. This practice created the impression that the documents were co-produced by senior members of the partnership. This was reinforced by the guidance notes for many of the report sections which appeared to phrase their directions in a neutral manner. However, this impression was disrupted by the presence of two sections. The first was the Project Beneficiaries’ section in which the evaluators specifically ask for “quotes from overseas health workers, partners, stakeholders, patients”. The explicit naming of who they wished to hear from was taken as a form of othering, that signalled an implicit assumption

that the authors would not be from this list of identified people. It is not possible to speak to intent, yet it may be more reasonable to speak to priority. The spaces provided throughout the report indicate the need for one response. This structure relied on the assumption that there will be a consensus as to how the question can be answered.

The second report template section which explicitly invited the LMIC partners to contribute to the document was the Lessons Learnt section. Within this section the leads for each side of the partnership were invited to “describe one piece of work that went better than expected”, and “one piece of work that went worse than expected”. What was notable about this was the imposed limit on the number of examples that could be provided. Given the sparse number of report sections which differentiated the voices within the partnership the imposed limit on the number of comments appeared to further restrict the scope of what the LMIC partners could have conveyed.

The adoption of these structures was seen as imposing restrictions on the possibility for the production of differing or conflictual accounts. In these documents the adoption of these structures also signalled a dynamic in which the perspectives of the HIC partners were implicitly prioritised and empowered and the LMIC partners were positioned as recipients of largesse. This may have been the result of procedures which placed the document in the possession of the HIC partners. It could also be argued that this structure was adopted as the HIC partners are contractually obligated to provide feedback on the project in a manner that their LMIC partners are not. However, while these points may be true, the adoption of these structures also spoke to issues of power, which become problematic when considered alongside debates about the ethics of doing work ‘with’ rather than doing work ‘to’ LMIC partners.

The researcher also noted that throughout the entire report template there were four subsections which were given an imposed word limit (see Table 4.6). Each of which were a section requesting reflective data.

Table 4.6 Report Sections with Imposed Word Limits

Report Template Section	Word Limit
Section 3.2.1 Other Project Achievements	300 words

Section 3.2.2 Overview of Project Highlights	300 words
Section 3.4 Measurement and Evaluation	300 words
Section 4.2 Other Changes in Partnership	200 words

Of the four sections noted, three were inviting the authors to provide descriptive data. The researcher of this project questioned the evaluators use of these imposed limits. The rationale for the limit on section 3.2.2 the overview of project highlights made sense as the sections merely summarised the large open text of section 3.1 progress against indicators which preceded it. The word limit to section 3.2.1 made less sense as it was designed to capture data that were not directly related to the indicators (outputs, outcomes and goals) of the project. The evaluators provided the following guidance:

“The agreed indicators are the core quantitative data that we expect to demonstrate progress in your project, but your project plan and grant application set out other anticipated results. Please summarise below any significant progress, anticipated or not, which you have observed during this reporting period that relates to the project objectives.”

This statement served as a signal that for the evaluators the concept of progress was not all encompassing. This statement made a distinction between two types of progress, that which pertained to the ‘agreed indicators’ and ‘other results’. This distinction generated the impression that the different types of progress were valued differently, and thus the limit on what could be conveyed signalled the potential value of this type of progress to the evaluators.

Section 4.2 followed the section where authors were asked to evaluate progress on the partnership development goals. The word limit in this instance appeared to also have been imposed on the assumption that the projects were unlikely to develop in ways that were outside of the development goals. Section 3.4 was classed as an evaluative section and was therefore discussed under that heading.

Following the sustainability section was the measurement & evaluation section. This was identified as requiring data on what worked well, the challenges and what the authors would have done differently. As already mentioned, this was one of four subsections where there was an imposed limit. What was interesting about this section was what the evaluators did not ask the authors to speak to. The authors were not asked to evaluate how reliable, valid or ethical their measures of change were in light of their experiences. This could be speaking to the assumption that the HIC staff possessed a level of expertise that did not require these forms of evaluation, only how they were received. Alternatively, this could also have been indicating that the evaluators were not interested in such information.

4.1.2 Distribution

Throughout the report template several comments were noted as indicating processes of distribution, for example, the evaluators mention that this report would “form the basis for reporting to DFID” in the guidance at the beginning of the report.

4.1.3 Consumption

The evaluators also stated that “submitting this final report to us on time is crucial for DFID’s assessment of the current scheme in its final year”. The use of the word ‘crucial’ was seen as not only referring to the timing of submission, but also to the need for data in itself. This was echoed by the statement

“Any delays in submitting the completed report as well as answers to our follow-up questions could affect the quality of our final HPS report to DFID and may also leave us with insufficient time to process your final grant payment”.

These comments appeared to serve the function of impressing upon the authors the need to be both timely and clear in reporting their project work, as well as using an implied threat to highlight the potential consequences of not doing so.

The evaluators also noted that “our feedback will be sent very soon after the report is received and answers to our requests for clarifications should be answered promptly”. This was seen as signalling that the reports would be under close scrutiny and that the authors should expect comments and

clarification. The evaluators allude to these reports being part of a series of reports which made up their periodic review of a project. These final reports were differentiated from other review reports as they

“included sections covering the overall progress of your project since its inception and the sustainability of results”.

This differentiation indicated that the previous reports may have only required the authors to comment on incremental progress for a defined period. The comment thus served the function of alerting the authors to the need to think about their project in its entirety.

4.2 Discursive Analysis Phase

One of the aims of this section of analysis was to identify the discursive and interactional practices used by authors in communicating the work conducted by IHP's. The other aim of this analysis was to highlight how the interplay between the structural and discursive features within the text indexed different discourses (see Appendix F for sample of analysis process).

4.2.1 Interactional Practices Used Across Documents

The individual IHP project reports were analysed to gain understanding of how IHPs use language to communicate the work they carried out. In attempting to identify the interactional processes attention was given to the rhetorical devices and styles of communication used. The analysis indicated that the style of communication used in these documents served particular functions, and the following is a summary of several such processes identified in the text.

4.2.1.1 *Anecdotal Evidence:* Anecdotal evidence was used several times in four out of the five documents, and in each case, it was used as a means of magnifying the perceived impact of the work that had been carried out.

Occasionally, the authors would openly acknowledge that the claims they had made were based on anecdotal evidence. However, more often the claims made framed as having occurred from aspects of change that were not the intended outcomes, and thus not anticipated as something that should be measured or quantified. This may be a result of the constraints embedded

within the document which exclude experience from the construction of 'evidence'.

One example of this can be taken from the overview of project highlights section of Document A. The authors report that "the attitude of staff towards patients has also improved whereby patients and carers are viewed as partners in the care process". This point was sandwiched between two other comments. The preceding comment was an acknowledgement from hospital staff towards the Peer-Support Workers (PSWs) for their impact on the wards. This point was substantiated by the inclusion of contextual information about the insufficient staff numbers, and listing some of the actions of the PSWs such as teaching patients to read and write. The point following this comment pertained to perceived changes in hierarchy within the service that was substantiated using the example of increased status given to a specific role. Thus, compared to the assertions surrounding the comment about changes in attitude, the lack of data given to support the comment meant the assertion could only be regarded as anecdotal. When considering the function of this comment, the researcher recognised that the inclusion of patients and carers in the processes of care is a high priority within the HIC context. As such, making the statement signalled the virtues connected with discourses of 'patient centred care'. In so doing the authors endowed their project with the ability to shift cultures so that they reflect the values held in the HIC, however this was not easily conveyed without referencing experiences.

Another example of this was drawn from the same overview of project highlights section of Document E. Unlike the previous example which utilised prose, in this report the authors listed out their achievements in short sentences. One comment of note was as follows

"As well as meeting the outcomes in terms of skills, knowledge and competence (as described in the above points). We believe that one of the greatest achievements is a palpable change in culture across the hospital."

In this text the authors explicitly identify this change as "one of the greatest achievements" of their project. What was significant about these comments was the use of the word 'palpable'. In using this word to describe the change which took place, the authors created the impression that in order to perceive the change one would need to be present within the culture. That the change was

obvious and tangible to those present, even if it existed outside of the evaluator's conception of 'evidence'.

From the examples laid out above, it is possible to see that the use of anecdotal evidence represented a distinct style of speech. One where authors could create positive impressions of their work which would otherwise not have been included due to the conception of evidence.

4.2.1.2 Omission: Authors were observed to have omitted pieces of information from their responses in various report sections. This was done through the omission of whole sections of text and also through the omission of smaller pieces of text.

One example of a large portion of text being omitted was taken from the project activity section of Document D. The authors were asked to identify which activities were complete, incomplete or cancelled. The authors marked five activities as incomplete and an additional two were marked ambiguously as both complete and incomplete. However, in the section that followed where they were invited to comment on why these activities were incomplete, the authors omitted five out of the seven activities. These activities included:

- The arrangement of a “joint contract position between HIC trust and a HIC University to develop the evaluative processes and investigate the impact” of their community activities.
- Obtaining “MOH consent to constitute a local patient safety expert group”.

Each of these activities were seen as having important consequences on the impact of their project, and if they were deemed to be no longer necessary the rationale behind this should have been communicated.

Additionally, as this project was reported to have been carried out in two LMICs simultaneously, it was interesting to note that of the 28 activities listed only one was differentiated by location. This was felt to be significant as the rest of the report documented change and progress as it pertained to both LMICs. Thus, in this example the omission of differentiating data created only one narrative of when in the project lifespan activities were completed. This would have been appropriate had the authors been able to demonstrate that the activities did

indeed occur at the same time and in the same manner, which was highly unlikely to be the case given the different LMIC partners involved.

Another example was taken from the progress against indicators section of Document C. This section required authors to answer a number of qualifying questions in their evaluation of their work. For example, where the authors had been asked to comment on the management, collection and interpretation of the data provided as evidence in the progress against indicators section. The evaluators provide guidance for the type of questions that would need to be answered in order to provide a satisfactory response:

“Where did the data come from, how reliable is it, what challenges have you faced in collecting and managing it, how meaningful is it as a measure of progress?”

In Document C the authors provided no data to answer the aforementioned questions for several indicators, namely output 1 and 2, and outcome 2. Output 1 pertained to the “proportion of trainers who are able to co-produce and co-deliver a sample lesson on recovery”. Output 2 was dual focused and pertained to firstly the “proportion of trainees who “pass” M&E training at post-test” and secondly the “mean difference in pre- and post-training test scores, expressed as a percentage”. Outcome 2 pertained to the “proportion of PSWs and staff meeting benchmark for validity and timeliness of reporting”. For each of these indicators the questions of reliability, and meaning were seen as highly important as they spoke to the potential impact of the findings. The lack of data provided served the function of obfuscating the evaluation of these indicators, and thus make it difficult for them to be judged as either sufficient or insufficient in supporting the claims of the authors.

4.2.1.3 *Rhetoric of Argument:* Another method used by authors to hide data that created a negative impression of the HIC team was through their use of the rhetorical device ‘rhetoric of argument’. This was where authors constructed arguments that conveyed the impression that the actions taken were the logical response to the situational factors present.

One example of this was taken from the project results section of Document C where authors commented

“The intention was to train the head nurses in each ward, who would then step-down this learning to all of the staff they supervise. However, this step-down process did not appear to be successful. There was also a reduction in the number of staff who had started referring early on in the project, due to annual rotations of staff (e.g. one staff moved from [X], a referring ward, to Outpatients Department, which is not a referring service to PSW). Another staff of [X ward] fell sick, and when she returned, was no longer interested in participating... we had to develop an incentive structure for accurate referrals” [sic]

Within the account is the formation of the problem as the number of staff who were referring service users to the project. The problem is then contextualised as being the result of “annual staff rotations” which disrupted their intention to utilise a particular staff group as conduits to disseminate their information and practices. The authors end the account by offering their solution to this problem which was to provide monetary incentives to staff to increase referrals. This account was interpreted as constructing a picture in which staffing and sickness were the problems. The reference to the staff movement being an annual process indicated a potential oversight in the planning stage of this indicator. As this was not a common practice in the HIC partners context it represents an assumption about how services operate that was not properly explored with the LMIC partners who would have been aware of this process. However, the argument put forward did not acknowledge these issues and thus removed indicators of the HIC partners partial responsibility in the matter.

Moreover, the solution offered in the form of monetary incentive appeared to have opposed to the construction of the problem as being tied to staffing levels and staff sickness. The researcher did not question the legitimacy of staffing and sickness as factors affecting project work as these are common factors effecting the delivery of care across context. The text appeared to highlight an assumption that LMIC staff would be compliant with facilitating the tasks needed to support this project without any form of remuneration. However, this was challenged by the reluctance of the staff to consistently engage with the programme. In summary, while both of these arguments were conveyed in a logical manner, their construction was interpreted as framing the situation in a manner that decreased the likelihood of the evaluators being able to attribute

the decisions made to the internal influences of the HIC team, and as such decreased the space for both partners to be held accountable.

Another example of where rhetoric of argument was used was taken from the finance section of Document B where the authors commented on fluctuations in spending over the course of the project. Authors stated that:

"The major challenge we faced was the significant overspend of £11,429 on the conference (line 74 of the financial report). Instead of two one day conferences in each year of the project at an estimated cost of £5,925, our partners requested a two day conference which required more accommodation and catering for both speakers and delegates, the majority of whom needed to spend three nights in [X city]. It could only be held after the final teaching module and once the trainees' projects were completed ready for presentation. The Second National CAMH Conference was heavily oversubscribed with 180 delegates instead of 100 that we had budgeted for, resulting in increased numbers for accommodation, catering, and travel" [sic]

What was interesting about the way in which this explanation was constructed, was that when asked about how the finances were managed in an earlier section the authors had acknowledged that the finances for the project were managed jointly. However, the reference to "our partners requested a two-day conference" created the impression it was the LMIC partners decision alone that created the problem. The reference to the two one-day conferences and their estimated amount was interpreted as positioning the authors as having been well planned and prepared. While creating the contrast that their LMIC partners were not either of these things. This positioning was echoed in a comment that followed where authors stated

"We were aware that we had under budgeted for the conference but we were planning to offset any increased expenditure against the significant accumulated under spend overall for the project because of careful budgeting to keep costs down overall and significant savings from UK travel costs" [sic].

The use of the term "careful budgeting" was connected to the actions taken by HIC partners as they pertained to travel costs, and was magnified with the

reference to “significant accumulated under spend”. This text was interpreted as again positioning the HIC partners as well planned and financially astute. Thus, the authors being positioned in this manner served the function of shifting attention away from them and thereby attributing responsibility on the LMIC partners.

4.2.1.4 *Summary of Interactional Processes:* When taken collectively, the style of speech and rhetoric devices used within these documents were seen as fulfilling specific functions. The use of anecdotal evidence to signal virtues in the work that were constructed as only being able to have been experienced by those present created a positive impression of the HIC achievements which would have been difficult to challenge. Additionally, the systematic use of omission of data were interpreted as ways of minimising the potential for evaluators to garner a negative impression of the HIC contribution to the project work. Lastly, the rhetoric’s of argument noted in the text appeared to position the HIC partners in a favourable light, whilst having positioned their LMIC partners less favourably as the source of difficulties. These were important to note as they demonstrated that whilst IHPs do indeed bring about change in the provision of services in the LMIC context, the way in which the work is communicated was far from neutral.

4.2.2 Discourses

The following is an account of the discourses identified through this research. Sunderland's (2012) guidance on the identification and naming of discourse was adopted. Sunderland makes a distinction between text and discourses using an analogy of fabric. In this analogy the discourse is the fabric which contains in its formal features’ multiple linguistic threads. These threads index how the fabric was produced, as well as providing some cues for how it can be understood. To extend this metaphor, the weaving of linguistic threads means that there are often no clear and fixed demarcations between discourses. They may “support or oppose each other, and may also ‘feed off’, ‘seep’ or ‘leak’ into each other” (Sunderland, 2004, p. 45). Thus, Sunderland (2012) asserts that there is no typology of discourses, from which names can be withdrawn. In light of this a mix of descriptive and interpretive titles were used to name the discourses identified in these documents. Moreover, the researcher recognised

that within a piece of text there can be an infinite number of discourses being indexed, the following were chosen for their connection with the research aims.

4.2.2.1 *Discourse of Resource*: There were occurrences in the text where authors indexed issues of resource. The sub-discourses detailed below encapsulate the formation of the type of resource issues faced and the solution utilised by many IHPs.

4.2.2.1.1 *Discourse of Inadequate Resource*: One of the dominant discourses which pertained to resources, was that the LMIC was inadequately resourced, and it was the lack of resources that hindered the efforts to achieve development.

“Information gathered from staff interviews indicated that staff were using some but not all of the tools and scales, and this was largely affected by the amount of time they had available with individual client” [sic] (Document A).

This text used the example of high numbers of service users the time taken to meet their needs as a way to reference issues of resource. The implication being that if there were more staff or more time, staff would have been able to utilise the new techniques they were exposed to through the project.

“A new intake form has been developed to include specific questions about alcohol and drug use however this is not being used universally yet due to cost implications” [sic] (Document A).

This text referred to the “cost implication” which presented as a barrier to this project achieving its goals. Indicating that if the LMIC organisation had more financial resources staff would have been able to utilise the knowledge and skill they were given through the project.

“Although confidence in teaching and clinical training have increased, it will be crucial to sustain motivation and group cohesion. Trainers will require support to leave busy work stations and funding for travel” [sic] (Document B).

This example highlighted the issues of funding and workloads as a means of indexing the discourse of inadequate resources. They posed these two issues as having a deleterious effect on the motivation and cohesion of staff.

The presence of this discourse was not surprising given the well documented lack of provision for mental health within LMICs which has formed part of the argument for the need for intervention. What was striking about the occurrences of this discourse within the text was how little projects did to address this issue. One example of this was taken from the project results section of Document D where authors were commenting on the difficulties with introducing a new documenting process for incidents in an LMIC hospital. The authors described LMIC staff as ‘being receptive to the new practice’, but noted that the incident books were “sometimes missing or hidden away”. The authors offered the hypothesis that this was possibly due to wards [being] understaffed, [and] thus health providers had limited time to document incidents”. Within this example even though there was an acknowledgement that the lack of resource was having a potential impact, the authors offered no examples of how they had attempted to address this barrier. Given that the documents were used as a source of data from which to evaluate the work of each project, the use of this discourse appeared to serve as a justification for the lack of progress made. In that, it appeared that the authors had used this discourse as a way to redirect attention away from questions of adequate planning and delivery, towards normalised barriers to progress.

4.2.2.1.2 *Discourse of Volunteerism:* Within each of the final project reports the other use of the discourse of resource was in the depiction of the solution adopted by IHPs. One example was taken from the Unforeseen Activities section of Document C where authors stated that:

" We had identified some challenges in undertaking some aspects of the project, such as training in supervision, further support in financial reporting, manualisation, etc, so when the opportunity to apply for extra volunteers was offered. This has made a highly significant difference to the support and communication in the project" [sic].

In indexing the high number of tasks which required attention as a challenge, the authors drew on the discourse of inadequate resources. The use of volunteers as the proposed solution to this issue spoke to the inability of LMIC partners to provide more resources to address the issue. In referencing “the opportunity to apply” this example highlighted a distinction between types of volunteers. The type of volunteers highlighted in this text were those generated

from the HIC organisation, for whom the HIC partners had applied for grant funding. The other type of volunteers referred to in the documents were those generated from the LMICs.

“In [LMIC X], project of this nature is believed to have more funding, and therefore, volunteers and agent normally expect some form of remuneration for carrying out activities. It’s very difficult their voluntary commitment without any return” [sic] (Document D).

“The lack of monetary incentive discouraged initial participation of some of the personnel” [sic] (Document E).

“Due to the extra workload required for the comprehensive and adequate completion of referral forms, it was agreed to pay a nominal incentive to ward based staff and community based staff” [sic] (Document C).

What was interesting about these text examples was that they indicated a lack of financial provision set aside for this group. This difference appeared to speak to the assumption that LMIC volunteers do not require financial remuneration. This view was echoed by the comments of an LMIC staff member in the project beneficiaries’ section of Document B,

“This will call for a spirit of voluntarism, hard work and self discipline among CAMH workers in this country. On my part I am willing to be part of the volunteers to collect and analyse this data come April 2017” [sic].

Thus, this discourse was used to propagate the idea that development within the LMIC context was reliant on the hard work of those giving their time, some of whom would be remunerated and others not. However, in trying to advance the agenda of development utilising voluntary labour many of the projects encountered issues of sustainability. Only one of the project reports analysed provided an example of where the systems around the volunteers were constructed in a manner that facilitated the volunteers to earn money from their work and use a portion of this to support the longevity of the project.

4.2.2.2 Discourse of Capacity: Another discourse indexed within the text was that of ‘capacity’. At times this discourse was indexed through text imbedded within the outcomes of the different projects:

“Number of staff achieving an adequate score in the final assessment of skill and competence”, [sic] (Document E).

“Staff demonstrate increased knowledge and skills compared to baseline each year”, [sic] (Document A).

“Number of paediatricians and child health professionals trained and demonstrating competence”, [sic] (Document B).

The use of this discourse in the formation of project outcomes was taken to indicate the areas of perceived lack within the LMIC context. Whilst historically, this lack had been framed around the amount of resources allocated to health (of which mental health was a small part if present at all), these outcomes were expanding the conversation to refer to the knowledge and skill needed to provide a service. As such, capacity was understood as an overarching discourse which encompassed the sub-discourse of knowledge and skill.

4.2.2.2.1 Discourse of Legitimate Knowledge: As it pertained to the capacity discourse of knowledge, the researcher interpreted the data to have indexed the sub-discourse of legitimate knowledge.

In Document A where the focus of the project was to “strengthen substance misuse interventions”, this discourse appeared in the construction of the baselines against which progress was measured. Professionals were expected to possess at “least knowledge and skills in heroin and detoxification”. The words used in this baseline spoke to an expectation that the LMIC would have lacked the ‘knowledge’ and ‘skill’. This was a remarkable assertion given that the baseline did not reference any means of quantifying the knowledge or demonstrating its relationship with other standards of knowledge for similar staff groups within other countries. The authors later noted that the knowledge was quantified using post-intervention questionnaires, but did not mention the use of any corresponding pre-intervention measured against which the changes could be compared. This was interpreted as corroborating the same assumption embedded within the phrasing of the baseline itself. Additionally, the focus on the ‘least’ amount of knowledge possessed was seen as having positioned the LMIC staff in a way that overshadowed the amount of knowledge that might have been possessed.

Questions of the dominance of this discourse, which positioned the LMIC partners as lacking legitimate knowledge were raised, and considerations were made for the structural restrictions embedded within the document and the procedures of production referenced in the structural analysis phase. Both of these were seen as limiting the space afforded to the LMIC partners to directly challenge this discourse. The few sections where the LMIC partners were able to contribute were analysed, which provided evidence for a subjugated discourse.

The project beneficiaries' section of the same report contained an account from a LMIC staff member who was trained by this project. They stated that, "we were taught a lot of things but what we use here are better to our hospital". In this text the speaker refers to being taught many things, but their statement that what they already used was "better" signalled that contrary to the assertions of the authors the LMIC staff did not see themselves as lacking knowledge. Rather they saw themselves as possessing the knowledge that was a "better" fit for their context. This comment was interesting as it came from a person who had been exposed to the 'new' knowledge, and had made a valuation that it was lacking for their context. The same account also added that:

"For me I can say it has helped me much. It has given me confidence and helped me to work with those patients who have been affected with drug misuse".

In this account there was a clear message that the training had "helped", and one could draw inferences from the statement to support the idea that this was due to the knowledge imparted to the staff member. However, the thing explicitly accredited with having helped was the increased "confidence" of the staff member. These two sections of text together were taken as challenges to the discourse presented by the HIC partners that the LMIC staff lacked knowledge, as it was interpreted as suggesting that it was not the knowledge itself that "helped". This was taken as signalling that the process of training might have been more important than the knowledge being shared. The process of being formally trained by people with high ranking professional titles from an idealised HIC context might have endowed the recipient with the status of being the possessor of legitimised knowledge, and thus increasing their sense of confidence in their work. As such, the discourse of LMIC staff lacking

legitimate knowledge was one that presented the reader with a misleading picture of the effect of the work being carried out on the ground.

This discourse of legitimate knowledge was not used exclusively to talk about the LMIC staff, but also other LMIC partner groups. One example of this was taken from the sustainability section of Document D, where the authors commented the sustainability of project workers delivering mental health information activities to various communities across the LMIC. The authors gave this indicator a sustainability score of 4 out of 5 (5 representing completely sustainable). In the lessons learnt from attempting to sustain the progress made the authors commented

“It is not easy to sustain because we are dealing with community members [who have] different needs. Some may just want to benefit [from the project], while others are more committed [to helping people]. Especially dealing with [the] uneducated as they don’t understand project work”.

The use of the term ‘uneducated’ alongside the statement that “they don’t understand” the work, created a stark comparison of how the authors were positioned in relation to the LMIC communities in which they worked. The authors can be seen as making a value attribution to academic knowledge. Within this comment is the assertion that if the LMIC community had such knowledge they would be more committed to sustaining their project. This connected with tropes around intelligence that have been documented as systematically prioritising and devaluing certain types of knowledge. This argument appeared to omit any responsibility on the part of the HIC partners to convey ‘the importance’ of the project in terms the LMIC community could understand. It also obfuscated the impact of the material resources of the LMIC community which were likely to be influencing their motivation to sustain engagement with the project. This point is covered further under another discourse explained below.

4.2.2.3 *Discourse of Dependence:* Although the aim of the HPS is to bring about meaningful and sustainable change to the LMIC health landscape, the method of achieving this goal through long-term partnerships with short-term funding appeared to highlight issues of dependence.

“Sustaining the competence and skills within [Hospital X] is perhaps one of the biggest challenges faced by this project, as it requires periodic monitoring and up-dates from [HIC] partners. The need of constant updating sessions is not exclusive to the course in [LMIC X], indeed, practices in the [HIC] follow the same path and participants are constantly updated on competences and skills” [sic] (Document E).

This excerpt taken from the sustainability of results section of Document E used the phrase “the biggest challenge” to speak of the issue of sustainability. The authors framed this issue as being rooted in “the need” of the LMIC partners for “constant updating”. The framing of the ‘need’ as having required constant input was interpreted as having created the impression of a connection that could not be broken or disturbed. In having created this impression the authors were seen as having propagated the idea that ‘true’ sustainability where the LMIC partners are in no way reliant on their HIC partners was impossible. The authors attempted to normalise this idea by drawing a comparison with a similar intervention in their HIC context. However, the construction of training for the management of violence and aggression as requiring constant updating appeared to have exaggerated the process. The idea of ‘constant’ does not appear to accurately depict a process that in the HIC context is revisited annually.

Another example of this discourse was observed in the partnership overview section of Document D, where authors commented that

“At Institutional level management and administration have become more accustomed and familiar to the partnership and see it as integral to the future- building their capacity to deliver quality healthcare” [sic].

The use of the word ‘integral’ in this excerpt was interpreted as positioning the LMIC organisation as reliant on their HIC partners, and the reference to the future was interpreted as signalling the perceived longevity of this reliance. The impression from excerpts of this kind raised questions about the efforts made to achieve sustainability.

4.2.2.4 *Discourse of Largesse:* Several of the documents contained data that indexed discourses of largesse. Several examples of this were observed in the Partnership Development section of Document C. One such example was

where the authors commented that “In 2016 the [HIC org] were successful in hosting a consultant psychiatrist from [LMIC org] to undertake a three-month Commonwealth fellowship”. In this comment the authors positioned themselves as the active party who benevolently provided an opportunity to be endowed with knowledge and skill, whilst the LMIC partner was positioned as the passive recipient who was fortunate enough to have received said opportunity. Another example of text that connected to the discourse of largesse was where authors had noted that:

“The New Global Health Partnerships Manager recently travelled thrice to [LMIC]”... “face-to-face contact made successful relationship building between partners that facilitates future working together” [sic].

The identification of the role was seen to index the significance and importance of the person within the organisation. The authors successfully draw on ideas of the importance and scarcity of time to change the conveyed meaning associated with the number of interactions. Given that in many context, three interactions would be seen as insignificant, when combined with the position the interactions become repositioned as highly significant and costly. The authors went on to attribute the success of relationship building to these interactions. The LMIC partners were not overtly mentioned in this comment about how the partnership was developed. This overt focus on one person who was not part of the project team again positioned the LMIC partners as passive recipients of the generosity of the HIC organisation.

4.2.2.5 *Summary of Discourses:* We return to Sunderland’s (2012) metaphor used at the beginning of this section, where discourse was likened to a piece of fabric. Hopefully, it has become more apparent how the different discourses identified above were overlapped and interwoven into the fabric of IHP work. The following phase of analysis attempted to critically evaluate these discourses through exploration of how they might impact the processes of production, distribution and consumption.

4.3 Critical Analysis Phase

Wodak (2001, p. 2) described CDA as “fundamentally concerned with analysing opaque as well as transparent structural relationships... as manifested in

language”. For this reason, CDA seeks to critically investigate how inequality is “expressed, signalled, constituted, legitimised” in discourse (Wodak, 2001, p. 2). As such, the interpretation phase of the analysis focused on the relationship between the discursive and rhetorical practices used in the documents and how these related to issues of inequality. They were also explored for their connections to practices that exist outside the documents. What follows is the researcher's conception of how these practices were related.

4.3.1 Inequalities in the value of Partners

There were a number of practices indexed within the documents which signalled differences in how partners were valued which mirrored by practices outside of the documents.

4.3.1.1 *Lack of Co-creation:* It was noted that text within the documents signalled issues of production where there was a distinct lack of co-creation. This issue of co-creation was also observed to be present in the processes which surrounded the documents. In the guidance for the project results section the evaluators stated that authors were to “include the latest cumulative data for the indicators agreed during project planning and inception, as set out in” their “MEL plan and baseline data sheet”. The reference to the MEL plan and data sheet signalled processes of construction which predated these reports. In analysing the reports, the researcher noticed that many of them lacked baselines for their outcomes, which created difficulties when needing to demonstrate meaningful change as having resulted from their project activities. In attempting to explain these challenges authors drew upon discourses of legitimate knowledge, that positioned the LMIC partners and their systems as the problem. Author's gave examples of where there was a lack of information, or where the practice of documenting work was not consistent enough to allow for the thorough examination of progress. As the construction of plans and data sheets would have required explicit exploration and agreement of what data can be of use and how it can be accessed. The lack of baselines, the positioning of LMIC partners, and evaluator's references to existing plans were interpreted as signalling processes of construction to which the LMIC partners were either not present or marginalised.

This interpretation was echoed by the data noted in the Project Activity section of the reports. This section used a table to track when in the project lifespan

activities were completed. The assumption within this design was that the activities noted occurred within the lifespan of a project, which is conceptualised as beginning after approval of the project application. However, Documents B, C and E all indicated that their project planning and agreement of arrangements for data collection occurred two months after their projects had begun. These examples potentially signal a process in which HIC organisations are granted permission to carry out projects before they create joint agreement about the foci of projects and how the projects will operate.

Another example that spoke to the lack of co-creation was taken from the lessons learnt section of Document E, where the authors completely omitted the LMIC partners responses from the report. This was deemed to be significant as that section was one of two which specifically invited comments from the LMIC partners within the report. Additionally, given the evaluators assertion that the documents should be completed by both partners, the lack of LMIC partner voice in this example pointed to issues in the process of production. This lack of LMIC voice was interpreted as signalling the process which placed the project report template in the sole possession of the HIC partners. As the holders of the document, the HIC partners were able to censor what information would and would not be conveyed about their projects. Additionally, the authors had taken every opportunity to create a positive impression of their project. They left no other sections of their report blank, instead offering minimal statements such as “none” and “stated above”. Thus, having omitted the LMIC voice with no qualifying statement was interpreted as an attempt to minimise conflictual or contentious accounts and allowed them to create a unified positive impression of their work.

The potential lack of involvement in project planning being signalled, with the lack of space within the documents for the LMIC partners to comment on project work spoke to an inequality in how partners were valued, with LMIC partners actively devalued. This was concerning given the UK Governments position on “working with other development partners to ensure development assistance reflects country owned priorities” and the need to assess “progress on the basis of targets and indicators agreed at country level” (HM Government, 2005, p. 13).

4.3.1.2 *Unidirectional Knowledge Transfer:* The researcher noted in addition to issues of co-creation, there were features of the reports which signalled a unidirectional flow of knowledge from the HIC partners to the LMIC partners.

As noted in the structural analysis phase, the report template contained a number of sections that were structured to facilitate the collection of reflective and descriptive data. The wording used in these report sections formed directions to guide authors on the types of data desired by the evaluators. For example, the guidance provided for the notes on incomplete activities and notes on unforeseen activities sections required authors to demonstrate why some activities were not completed and what impact they had on the project results. In the phrasing of the guidance the evaluators missed the opportunity to get authors to reflect on what each of these activities taught them about project work. This was interpreted as a loss of potential knowledge as both of these sections contained data that was not captured anywhere else in the report document. When explored further, it was noted that none of the guidance required authors to describe or reflect upon instances of bi-directional learning or reverse innovation. While there was a lot of learning shared within the reports, it appeared that the learning pertained to how HIC organisations achieved results and the barriers to achievement. This can be seen as signalling that the processes put in place to capture learning are only capturing the flow of knowledge into the LMICs. This process appeared to connect with the discourse of legitimate knowledge, and reinforced ideas there is little that can be learnt by HIC partners that would be of use within their own countries.

Discursively, aside from within the two report sections explicitly requesting it most of the reports analysed lacked data spoken from the LMIC partner position. This meant that the learning that was communicated generally represented one side of each partnership. Moreover, it was noted that none of the reports analysed contained data put forward by authors that pertained to learning gained in the partnership that could be considered reverse innovation.

Both the issues of co-creation and unidirectional knowledge transfer were interpreted as connected with the discourses of legitimate knowledge and largesse. These examples were interpreted as supporting the idea that health partnership work has often been done to LMICs rather than with them. They

spoke to processes which demonstrated a lack of value attributed to LMIC partners and positioned them as passive recipients. These processes were deemed important as they robbed the LMIC partners of the opportunity to meaningfully engage in the processes of reporting, which allows for the creation of conflicting accounts and thus the chance for partners to be held accountable.

4.3.2 Creation of Expertise

As previously mentioned, the discourse of volunteerism was observed to be referenced as the common way to address the shortfall in resources within LMICs. The apparent response to this from LMIC staff highlighted that this was not a feasible way to bring about change. However, the account referenced by a LMIC staff member in Document B appeared to have aligned with the HIC discourse of volunteerism.

“This will call for a spirit of voluntarism, hard work and self discipline among CAMH workers in this country. On my part I am willing to be part of the volunteers to collect and analyse this data come April 2017” [sic].

The presence of this account raised questions about what would be enough of a motivation to override the lack of financial remuneration indexed by other LMIC staff? The answer to this was believed to be connected to the discourse of legitimate knowledge. What happens when organisations endow knowledge to small groups of people within resource deprived environments?

[Hospital X] is now recognised by [Y] and [Z] regional mental health units as a Centre of Excellence in TMVA. This enforces the view that [X hospital] is a leader in mental health care and training in [their LMIC]” (Document A).

“[Hospital X] provides mental health training, supervision and mental health strategic work for the whole of [their LMIC] and has unusual prominence in Sub-Saharan Africa. Supporting and developing it as a centre of excellence has a significant impact on mental health provision elsewhere” [sic] (Document B).

“We have developed an excellent profile and respect at local and regional levels and our national profile is growing” [sic](Document D).

The answer indexed in the excerpts above is that those endowed with knowledge become the holders of expertise, which places them in a position of increased status within their context as those able to deliver excellence. Additionally, the prestige of the HIC partners imparting the knowledge further increased the status of those LMIC involved. Returning to the question about what would motivate a person to overlook financial remuneration in a resource deprived environment. It is possible to conceive that the processes involved the creation of experts would lead to more opportunities for those willing or able to bare the immediate costs.

4.3.3 Sustainability

There were a number of references within the text which were construed as having highlighted issues of dependence and sustainability. For many projects the introduction of new roles into resource deprived systems meant that the workloads were not sustainable using existing staff resources. As such, many projects demonstrated a reliance on volunteers to cover the shortfall. As already mentioned, the issue with relying on volunteers was that it reinforced economic systems where LMIC staff were not remunerated for increased workloads created by the projects. This was interpreted as placing the responsibility for development upon the shoulders of LMIC staff. Ultimately, the results of this were borne out in the project reports, as many of the IHPs struggled to demonstrate the ability to sustain the processes and projects that they had developed.

The researcher was able to view a preliminary IHP report, which indicated that evaluators had not been routinely collecting evidence of sustainability from the beginning of the projects. This shift towards measuring sustainability appeared to have coincided with the concerns raised about the lack of sustainability within the wider literature. As such, the multiple cases where IHPs were unable to demonstrate having achieved sustainability might be indicative of the lack of thinking required around this issue at the time of project conception. The project reports could be viewed as having contained data which indicated a theoretical shift towards sustainability, but in order to see changes in practice this would need to be present from project conception.

Bound up with the concept of sustainability is the ideal of self-sufficiency, with the hope that in creating systems that are sustainable, projects would decrease

the need for LMIC partners to depend on the input of their HIC partners. However, the lack of sustainability had in fact highlighted inadvertent creation of systems which would depend on the continued input of HIC organisations to sustain change. In addition to these cases of inadvertent dependence on HIC partners were cases where dependence on HIC partners was normalised. These accounts drew parallels between what had been established in the LMIC context and what was regarded as the status quo in the HIC context where the process of change relied on the validation of knowledge and skill from an external agency. Thus, it was interpreted that the idea of self-sufficiency was not achieved as it sat outside of the HIC partners frame of reference.

Within the literature surrounding IHPs was the acknowledgement that the lack of resources has made achieving and sustaining change difficult. However, the authors' references in the text drew attention to a cyclical relationship between policy and resource, where the lack of acknowledgement within policy influenced the lack of funded posts. In turn the lack of funded posts hindered the number of bodies operating within the area and thus the lack of information, demonstrating the need for increased resource. Of the five projects analysed, only one of them described/presented/considered their work as having made significant progress in breaking this cycle. This was the project reported on/described in Document B, where the IHP focused on the accreditation of a specialist university course. While all the projects analysed involved elements of training, having embedded this project within the university context appeared to have legitimised the knowledge to a population group with a wider reach. In doing this the project demonstrated higher significance for the impact data generated from the project.

4.3.4 Responsibility/ Accountability

Whilst multiple sections of the report template invited the authors to engage with what they learnt from their work, only the measurement and evaluation section explicitly asks the authors to acknowledge what they could have done differently. However, the specific focus of the section limits the extent of this type of learning. Whilst this might appear to be semantically small abstraction from what was asked, the implication is that the authors had the space to avoid taking ownership of any failings or shortcomings in the project, and the lessons learnt about many of the processes was lost. What was noted in most of the

documents was that unlike other constructions of evidence which were challenged, there was a lack of challenge to the restrictions on this type of learning being communicated. Moreover, the authors were observed to construct their accounts in a manner that purged them of responsibility, and created the impression that often the problems encountered were due to their LMIC partners. This practice can be seen as contributing to a lack of accountability which stunted learning about how partnerships could work together and whilst ensuring the continued support for this way of working through the construction of positive accounts of HIC partner activity.

4.4 Summary of Findings

The aim of the analysis was to highlight the different ways that health professionals speak about their work within IHPs, and the discourses evident within that speech.

The structural analysis phase of the analysis highlighted that although the process of producing reports is open to both sides of the partnership, LMIC partners voices are often marginalised. The processes of distribution and consumption highlighted within the text alerted readers to the ways in which the descriptive, evaluative and reflective data would be used beyond evaluating individual projects.

The reading phase of the analysis highlighted a number of rhetorical devices and styles of speech used by HIC partners in speaking about their work. These were largely seen as facilitating one of three functions. Namely:

- Talking about the work in a way which minimised the space for criticism
- Creating positive accounts of the work carried out
- Placing the responsibility for failings on the LMIC partners.

Additionally, the reading phase identified a number of discourses present within the IHP reports. The researcher noted discourses about the lack of resources and the preferred method of volunteerism as the means to address this shortfall. As well as discourses of around those seen to lack legitimate knowledge and those deemed to possess it who were positioned as experts. There were also discourses around how relationships with experts needed to be

maintained over time to ensure development in spite of the fact that the aim was to develop self-sufficiency within LMICs.

The interpretation phase of the analysis critically explored the various discourses highlighted and gave thought to how some of these discourses were present in the processes of production, distribution and consumption of IHP project data. The following discussion has drawn on all of the points from each phase to explore how they answered the research aims.

5 DISCUSSION & CONCLUSIONS

This research set out to explore the ways that health professionals talk about the work they do in IHPs. This chapter contains a discussion of how the results of this research connected with the research aims, the ramifications of the findings, and recommendations for practice and future research.

5.1 Connection with Research Aims

As laid out in the methodology section, the aims of this research were to determine:

- 7.7 What are the discursive devices used in communicating the work conducted in IHP's?
- 8.7 Do the discursive devices used by health professionals embody principles of partnership?
- 9.7 Does the way in which health professionals talk about their work connect with the processes which surround their work?

The results section documented the various rhetorical and discursive practices identified by the researcher as being used by UK NHS staff in communicating their IHP work to their funders. The authors accounts were interpreted as lacking methodological rigour in the lack of clear baselines, and reliance on anecdotal accounts. The systematic omission of data along with authors arguments that rhetorically minimised their part in project shortcomings, were interpreted as effective ways of creating superficially positive accounts. The way the accounts were constructed were interpreted as a feeding into discourses of

capacity, resource, dependence and largesse in ways that positioned the LMIC organisations as passive recipients rather than active and equal partners. However, given the processes of consumption in which evaluators only utilised the quantitative positive information, the perceived repercussions for constructing accounts in this way appeared low.

In comparing the communication within the reports to the PoP, the researcher would assert that many of the reports analysed provided evidence that their partnerships were operating in a 'strategic' manner. For example, as referenced in Table 4.1 all of the projects focused to some degree on the transfer of knowledge, which required them to create spaces within existing institutions where they could engage their target population. Each partnership demonstrated that their project was planned and executed in a manner that would maximise their reach and impact. However, only one partnership demonstrated that the aims of their project were 'harmonised' with the aims of their LMIC partners. This was observed in referencing changes in the national policy, although their contribution to this was poorly evidenced. The remaining accounts conveyed that many of the projects were top-down approaches to issues identified by the HIC partners. The reports conveyed a sense of 'harmony' between partners, but the authenticity of this was challenged by the lack of co-production and minimal LMIC partner presence within the reports. This was seen as problematic because

"Without harmonisation, managing individual donor projects and dealing with different procedures imposed by donors can be very time-consuming for developing countries. This undermines a developing country's ability to lead the development process" (Government, 2005, p. 15).

In relation to the work being 'effective and sustainable', the lack of clear baselines against which to measure progress made has raised questions about the reliability of the results conveyed. Moreover, while several projects claimed to have achieved sustainable development for their indicators, their accounts signalled that this sustainability required reliance on the HIC partners and volunteers. Although the evidence suggested that both parties gained from these partnerships the aforementioned issues of sustainability were seen as impacting the extent to which the gains could be thought of as equivalent. The

presence of the discourse of legitimate knowledge, where LMIC staff were positioned as lacking the needed knowledge and skill. Alongside the negative attributions made about the motivations of LMIC staff who did not wish to engage in perpetual volunteerism, were taken as evidence for a lack of respect from the HIC to the LMIC partners. In relation to responsibility, the analysis of these reports demonstrated that HIC partners routinely avoided acknowledging their part to play in results that did not meet expected targets. Moreover, their accounts attributed the actions of their LMIC partners and their systems as the reasons for poor results. Although the reports demonstrated that each IHP was accountable to THET, apart from the references to questions and feedback from THET the analysis of these reports was unable to provide any further clarity on the nature of this relationship. The reports demonstrated how partners had to negotiate barriers to change together in order to meet their aims, with a minority having utilised innovative methods to do so. However, the analysis highlighted that knowledge and innovation flowed unidirectionally from HICs to LMICs. Although the documents devoted large sections to capturing reflective data, the commitment to joint-learning was interpreted as having been narrow. To the exclusion of learning that pertained to reverse innovation.

In thinking about how professional's speech in the documents connected with processes outside of the document, the project results documented in each report could be seen as having demonstrated development of the health services with whom they partnered. With many projects developing evidence where there previously was none. Given the commitment to create evidence-based global health policies and practices (DHSC, 2011; WHO, 2013) this was positive as it expanded the basis from which knowledge can be drawn. Fairclough (in Wodak & Meyer, 2001, p. 127) highlighted that in a knowledge-based economy where "knowledge and information take on a decisive new significance... knowledge is produced, circulates, and is consumed as discourses". Thus, the ways that rhetorical and discursive devices deviated from the PoP, raise questions about the reliability of the evidence being used to inform these policy decisions. The researcher wondered whether like the UDHR the PoP represented idyllic outcomes which lacked the framework to bring them into practice, in turn rendering them little more than hollow words.

Additionally, in their framework for global health DHSC (2011) highlight that in evaluating the ways UK organisations meet its international aid policies there has been a shift away from monitoring processes towards monitoring outcomes. This was acknowledged in 'Our mutual interest' (Chisholm, Green, & Simms, 2016) where THET highlighted how the politics surrounding how international aid is distributed has led to increased focus on evidencing how IHPs are working in the UKs national interests. This was felt to be present in the evaluators focus on impact of achievement (or lack thereof) rather than reflecting on the process despite the outcome. This was also identified in the way authors actively avoided answering questions that pertained to processes. Which was seen as facilitating the maintenance of positive outcomes. Thus, it was interpreted that the reports had the potential to capture more learning, but this was limited by adopting position of prioritising outcomes over processes. This issue appeared similar to the well documented research practice of not publishing findings which yielded insignificant or negative results (Dwan et al., 2013; Ferguson & Heene, 2012; Laws, 2013; Vasilev, 2013). The researcher would argue that whilst the focus on outcomes is more pragmatic, what is lost is the incremental pieces of knowledge that are necessary in the efforts to share learning and scale up sustainable projects.

Much of the analysis spoke to issues of power within both the partnerships and the systems which create them. In speaking on power, Fricker (2007) identified that there are active and passive forms of power. The former being directly employed by those endowed with power, and the latter being imposed by the systems and structures which endow particular actors. In this sense the processes surrounding the construction of IHPs endowed the HIC partners with active power as the holders of resources and knowledge. This active power is mobilised "to define and effectively own the agenda for policy and research" (Gill & Benatar, 2016, p. 351). As such, this power asymmetry can be understood as passively operating to influence behaviours such as the agreement of LMICs to engage in partnerships where their choice in foci and other decisions is constrained. The use of these forms of power constituted an example of testimonial injustice (Fricker, 2007). This was based on the way the rhetorical and discursive devices used in the text were interpreted as having fed into pejorative depictions of LMIC partners, that in turn normalised their limited and minimal presence within the documents.

Additionally, whilst the ways that HIC partners have communicated dominated much of the results and discussion; the structural analysis highlighted that the way THET constructed the report played a large part in determining what was communicated. As such, their position of power and influence situates them to redress the way that discussions of IHPs are constructed.

Separate but connected to the issue of power was the way dependence was demonstrated. As the analysis highlighted that several of the partnerships were unable to achieve sustainability, instead documenting the need for continued dependence, the researcher wondered whether this issue was being perpetuated by the drive to further develop this way of working. Hong (2000) argued that as global health increased the inequality between nations it also made it appealing for countries to position themselves as needing help. In so doing they secure future aid, investment and partnership that would otherwise not be present, and thus need to be relied upon from their own governments. In this way, global health has become an industry which has thrived off of the disparity between countries, and created systems which maintain such relations.

In a similar manner the HIC organisations involved in creating new expertise also gained from engaging in this practice. The staff members provided to support each project gain expertise in service development and scaling-up. As well as the opportunity to achieve increased status through dissemination of project work through publications and conference presentations. Additionally, the organisations that they are a part of also stand to achieve increased status from all of the aforementioned points.

Lastly, the UK government also gains from this work. It increases its position as a world leader of development, and thus becomes the international partner of choice for LMICs wishing to experience health development.

If the argument of knowledge as the biggest resource to be utilised in the exchange of GH and GMH is upheld, then it could be argued that amongst health professionals CPs are uniquely positioned to make a positive contribution to the various layers of practice. CPs core training requires them to acquire knowledge and demonstrate skill in leadership, service development, research conception, construction, and implementation. All of which

differentiates them from other health professionals for who these are not core part requirements of their training. If combined with CPs established skills in the establishing positive working relationships and ability to utilise multiple approaches to the same issue, there is an enhanced potential to reduce the prevalence of the problems highlighted by this research. For example, the issues of establishing effective baselines against which to measure progress. Outside of direct project involvement, CPs skills in the critical analysis and interpretation of data could also be of great benefit to the organisations who are responsible for evaluating the work carried out by IHPs. Whilst the researcher recognised that many of the aforementioned competencies are not unique to CP, there is not another professional group as present within the NHS with these skills. Therefore, they represent a distinct opportunity to maximise existing staff groups, rather than creating entirely new roles for a system that we are supposed to be working to not be involved with.

5.2 Summery

In summary, while the reports demonstrated the facilitation of changes to the MH landscape of LMICs, if the accounts are to be taken as indicative of the ways that IHPs operate, then there remains much work to be done. The analysis of the text highlighted issues in the conception, construction and implementation of health collaborations. These issues have made it difficult to evidence the true impact and sustainability of their work, whilst the ways in which work is communicated has perpetuated negative discourses of LMICs, thus limiting the amount of bi-directional learning and reverse innovation (Harris, Weisberger, Silver, Dadwal, & Macinko, 2016; Harris, Weisberger, Silver, & Macinko, 2015). Additionally, the work documented within these reports highlighted a number of systemic issues. Such as, the power asymmetry between partners created by systems which rely on the legitimisation of particular types of knowledge. As well as the systems which approved and financed 'partnership' projects created without significant input from the intended partners.

This research has indicated that the work of decreasing inequalities in health between HICs and LMICs cannot be accomplished by project work alone, but require national and indeed international policy solutions (Gill & Benatar, 2016).

As these create frameworks upon which developments can be fostered and sustained.

5.3 Evaluation and Critical Review

Throughout the course of this research there were a number of issues which held implications for its conception and the interpretations drawn from its findings. Each have been discussed below.

5.3.1 Use of CDA Approach

CDA was adopted as it encompassed a broad range of methods and techniques that allowed the researcher to select the methods that best suited the research aims. Therefore, the selection utilised by the researcher represented one of many possible approaches that could have been taken to meet the same aims. The adoption of other methods and techniques might have yielded different results.

5.3.2 Subjectivity of Interpretation

Gill & Benatar (2016) asserted that the analysis of this kind should be evaluated by neutral third parties. This statement can be understood as referring to the evaluator stake in the work being scrutinised rather than a lack of emotional connection to the area of research. In this manner the researcher met this criteria. However, the lack of experience in the research area meant that whilst the scope of the analysis aimed to include the processes of production, distribution and consumption, this was difficult to achieve as these processes are not always readily accessible to outsiders and thus limited the connections that could be drawn (Rapley, 2007). This concern for interpretation bias was echoed by Sunderland (2004, p. 47) who highlighted that "discourse identification and naming of discourses from an interpretive, critical perspective are not neutral activities, but rather say something about the 'namer' as well as the discourses". As such, subjecting interpretations to the scrutiny of informed others limits their potential to be solely "the product of the analyst's particular interpretive proclivities". Had this been possible, it is possible that alternative interpretation of the same data might have been made. However, the context in which this research was constructed meant that the analysis had to be undertaken by one researcher.

5.3.3 Generalisability

In evaluating how much the findings of this research can be used to speak about the work of IHPs in GMH the researcher had to address issues that pertained to the following issues.

5.3.3.1 Data source: CDA asserts the analysis of multiple data sources to facilitate the triangulation of research findings (Fairclough, 2001; Wodak, 2001). This might have encompassed the use of questionnaires, interviews and observations, however this proved difficult for multiple reasons. Firstly, whilst previous research that had involved professionals, they had often only used service leads (Kulasabanathan et al., 2017). This left space for work involving lower cadres of professionals, however accessing these groups was extremely difficult and time consuming. Unlike senior staff, whose names were recorded on project reports, the details for lower cadres was not recorded. Thus, whilst not impossible the accessibility of staff represented a methodological challenge to the feasibility of the project (Willig, 2008). Secondly, the funds required to carry out observations within the LMICs were not present, and thus engaging with this data source became unfeasible.

The sample focused solely on the IHPs constructed by NHS trusts, which made up approximately a third of the total projects activated by THET to deliver on GMH. As such, the results are limited in their ability to be used for generalisations about how the work of all IHPs addressing GMH was communicated. However, as the reports analysed were of all NHS trusts bar one, they can be taken as highlighting ways of communicating which might be representative of this distinct sub-group. This is reinforced by the fact that the reports represented the only form of communication used to convey project results to funders, and thus they represented a distinct interaction.

5.3.3.2 Sample Size: The amount of data that returned from the FOI requests varied greatly between trusts. One trust who was approached was not able to provide any copies of their reports to THET. Whilst another trust provided a copy of their provisional progress report which documented progress from the middle of their project. A different trust provided pictures and song lyrics created through the partnership. Each of these documents represented a small piece of the overall interaction between those involved and thus held the potential to bring something unique to the analysis (Rapley, 2007). Thus, the

researcher had to make the decision between conducting the analysis on the data set considered to be the most representative, or carrying out a more in-depth analysis on the various sources of data for one trust. As demonstrated by the way this research has been constructed the researcher opted for the former. This decision created a smaller sample size, but provided more generalisable data.

5.3.4 Methodological Proficiency

Prior to this project the researcher was unaware of and unskilled in CDA, thus a great deal of time was spent learning the approach and determining which methods and techniques would best meet the research aims. This was difficult as the researcher struggled to find authors who had used CDA to similar aims. The unfamiliarity with the method meant that the researcher often felt as though they were lost in a maze, unsure whether a particular turn would help them to the end. This meant that the researcher engaged in double checking and rethinking impressions gained from the analysis going back and forth between the phases of analysis. It also meant that a sense of clarity about the discourses present and what they were being used to do arrived towards the later stages of write up.

5.4 Recommendations

The discussion underlined various issues in the practice of IHPs. From these, the researcher devised a number of recommendations that can be used to strengthen the evidence being produced by this way of working.

In order to better embody the PoP, THET should only approve applications for partnership which can demonstrate being co-constructed with LMIC partners. Thus, ensuring the promise of resource is not unfairly used to coerce LMICs into partnerships which do not reflect their concerns.

THET should provide a copy of the report template to the LMIC partners and allow them to complete reports throughout the project lifecycle to ensure that they have the opportunity to convey their version of how the partnerships are operating and influence future development.

THET should adjust the report template to create a section that can capture reverse innovation learning and provide authors with questions to elicit learning about the processes involved in achieving outcomes.

As THET already disseminated some of qualitative learning from the IHPs, this could be expanded to include the learning about overcoming barriers to sustainability.

HIC partners should place more emphasis on establishing clear baselines before intervening so that interventions are truly reflective of change.

HIC partners should provide their volunteers with enhanced training in research methods and reporting.

HIC partners should demonstrate learning about the processes involved in achieving aims.

LMIC Partners should routinely try to disseminate primary research findings for their projects.

The critical evaluation highlighted a number of shortcomings in the research design, which have fed into the creation of the following recommendations for further research.

Further research could explore

- A discourse analysis comparing final reports to applications
- The LMIC staff perceptions of IHP work
- The HIC volunteers' perceptions of IHP work
- A cost benefit analysis of the differences between volunteers and paid project workers (Ritman, 2016).
- Document analyse of the other documents produced as part of IHPs
- An analyse of the reports published by University and NGO based IHPs.

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7 APPENDICES

7.1 Appendix A - The Millennium Development Goals, Targets and Indicators

Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
<i>Goal 1: Eradicate extreme poverty and hunger</i>	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below \$1 (PPP) per day 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
<i>Goal 2: Achieve universal primary education</i>	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24 year-olds
<i>Goal 3: Promote gender equality and empower women</i>	
Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate women to men, 15-24 year-olds 11. Share of women in wage employment in the non-agricultural sector

Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
	12. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1 year-old children immunised against measles

Goals and Targets	Indicators for monitoring progress
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among pregnant women aged 15-24 years 19. Condom use rate of the contraceptive prevalence rate 19a. Condom use at last high-risk sex 19b. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 19c. Contraceptive prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

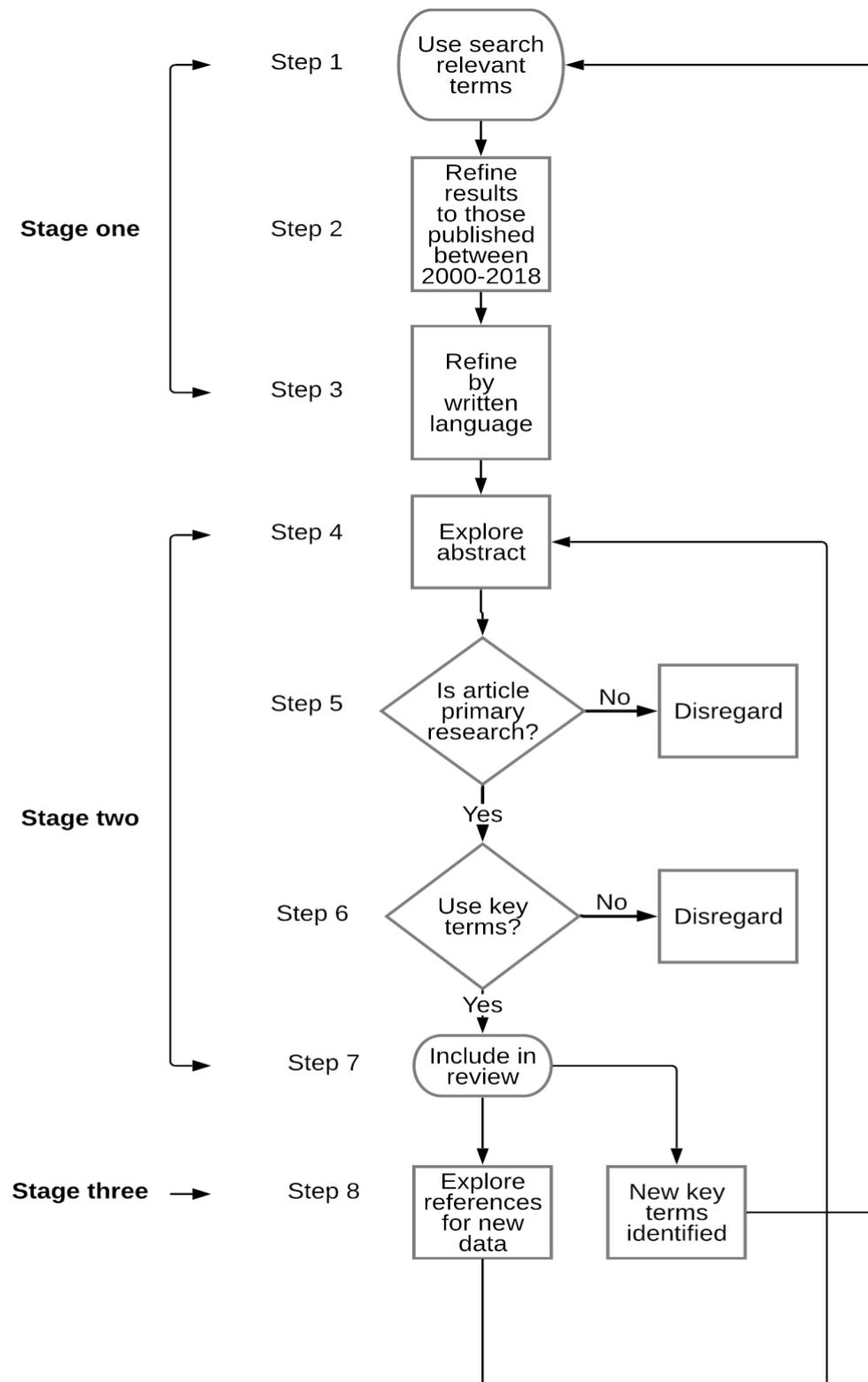
Goals and Targets	Indicators for monitoring progress
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measured 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course DOTS (internationally recommended TB control strategy)
Goal 7: Ensure environmental sustainability	
Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Ratio of area protected to maintain biological diversity to surface area 27. Energy use (kg oil equivalent) per \$1 GDP (PPP) 28. Carbon dioxide emissions per capita and consumption of ozone-depleting CFCs (ODP tons) 29. Proportion of population using solid fuels.
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural 31. Proportion of population with access to improved sanitation, urban and rural

Goals and Targets	Indicators for monitoring progress
<p>Target 11:</p> <p>By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers</p>	<p>32. Proportion of households with access to secure tenure</p>
<p>Goal 8: Develop a global partnership for development</p>	
<p>Target 12:</p> <p>Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally</p>	<p>33. Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income</p>
<p>Target 13:</p> <p>Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p>	<p>34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)</p> <p>35. Proportion of bilateral ODA of OECD/DAC donors that is untied</p> <p>36. ODA received in landlocked developing countries as a proportion of their gross national incomes</p> <p>37. ODA received in small island developing states as a proportion of their gross national incomes</p>
<p>Target 14:</p> <p>Address the special needs of landlocked developing countries and small island developing states (through the Programme of Action for the Sustainable Development of</p>	<p>38. Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty</p>

Goals and Targets	Indicators for monitoring progress
Small Island Developing States and the outcome of the twentysecond special session of the General Assembly)	39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as a percentage of their gross domestic product 41. Proportion of ODA provided to help build trade capacity
Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	42.Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 43. Debt relief committed under HIPC Initiative 44. Debt service as a percentage of exports of goods and services
Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	45. Unemployment rate of young people aged 15-24 years, each sex and total
Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18:	47. Telephone lines and cellular subscribers per 100 population

Goals and Targets	Indicators for monitoring progress
In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	48. Personal computers in use per 100 population Internet users per 100 population

7.2 Appendix B – Scoping Review Decision Tree



7.3 Appendix C – Sample of Scoping Review Extraction Table

Authors	Date	Title	Analysis method	Participant focus	Type of health	LMIC authors
Alemu, S., Dessie, A., Tsegaw, A., Patterson, C. C., Parry, E. H., Phillips, D. I., Trimble, E. R.	2015	Retinopathy in type 1 diabetes mellitus: Major differences between rural and urban dwellers in northwest Ethiopia.	Quant	Patients	Physical health	Yes
Ali, B., Tomek, M., Lisk, D. R.	2014	The effects of epilepsy on child education in Sierra Leone	Mixed methods	Patients and carers	Physical health	Yes
Aveling, E., Zegeye, D., Silverman, M.	2016	Obstacles to implementation of an intervention to improve surgical services in an Ethiopian hospital: a qualitative study of an international health partnership project	Qual - interviews, observations and document analysis	LMIC System	Physical health	Yes

Baillie, D., Boardman, J., Onen, T., Hall, C., Gedde, M., Parry, E.	2009	NHS links: Achievements of a scheme between one London mental health trust and Uganda	Mixed methods	LMIC staff	Mental Health	Yes
Berhanu, S., Alemu, S., Prevett, M., Parry, E.	2009	Primary care treatment of epilepsy in rural Ethiopia: causes of default from follow-up.	Qual - questionnaires	Patients	Physical health	Yes
Berhanu, S., Prevett, M.	2004	Treatment of epilepsy in rural Ethiopia: 2 year follow-up	Qual - document analysis	Patients	Physical health	Yes
Bowen, J. S., Southgate, R. J., Ali, A. M., Little, S. J., Liakos, A., Greaves, F., Strachan, J. M., Baraco, A. F.,	2012	Can UK healthcare workers remotely support medical education in the developing world?: Focus group evaluation.	Mixed methods	LMIC Staff	Physical health	Yes

Adem, G., Abdillahi, M., Handuleh, J., Reed, K., Walker, F., Zeron, J., Strachan, M., Bowen, S., Hellyer, T., Hersheson, J., Whitwel, S., Fyfe, M., Phillips, J.C., Trim, C., Johnson, O., Leather, A. J., Finlayson, A. E., Al-Hadithy, N.						
Bowen, L., Zyambo, M., Snell, D., Kinnear, J., Bould, D.	2015	Evaluation of the accuracy of common weight estimation formulae in Zambian paediatric surgical population	Quant	Patients	Physical health	Yes

7.4 Appendix D – Freedom of Information Request Email

To whom it may concern,

I am contacting you because of your organisation's involvement in the Health Partnership Scheme with the Tropical Health Education Trust.

I am a doctoral level researcher interested in work of NHS Trust engaged in the HPS, particularly those focusing on Mental Health.

In accordance with the Freedom of Information Act I am requesting all the reports written about the HPS work. In particular I am interested in the targets set for the work and the reports about how the targets were met. Additionally, I am interested in any publications produced about the work undertaken.

Kind regards.

XX

**Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology
University of East London**

7.5 Appendix E – Health Partnership Report Template



HEALTH PARTNERSHIP SCHEME FINAL REPORT

Partnership (Lead Partners)	
Project Title	
Grant ID	
Project Start and End Dates	
Reporting Period	

Guidance

This reporting template provides you with the opportunity to summarise and reflect on recent achievements, partnership development and lessons learnt. As this is your final report, we have also included sections covering the overall progress of your project since its inception and the sustainability of results as a chance to reflect more deeply on some of the overall impact of your partnership work and to celebrate your achievements.

Reports form the basis for our reporting to DFID and for your payments to be released. Submitting this final report to us on time is crucial for DFID's assessment of the current scheme in its final year. **Any delays in submitting the completed report as well as answers to our follow-up questions could affect the quality of our final HPS report to DFID and may also leave us with insufficient time to process your final grant payment.** Please note that our feedback will be sent very soon after the report is received and answers to our requests for clarifications should be answered promptly. Thank you in advance for your cooperation.

- Please read through all sections of the report before you start writing to avoid repeating content unnecessarily;
- We expect both the UK and overseas partner to contribute to this report and ask separate contributions in the Lessons Learnt section;

- If you have any questions about this narrative or the financial reporting template please do not hesitate to contact your grant manager, Peris;
- Please complete the report **no later than 15th May 2017** and send it to your grant manager at peris@thet.org .

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PROJECT TEAM

Where relevant please detail any changes in responsibility in your project team:

--

Who contributed to this report? Please include names and contact details.

Name and Position	Contact Details

Project Activities

Progress against activity plan

- If the activity has been achieved, please replace the relevant X with a Y.
- If the activity has been cancelled, please replace the relevant X with a C.
- If the activity has not been completed as planned, please leave the X in place.

No.	Activities	Timing of Activities																													
		Year 1												Year 2												Year 3					
		Month 1-6						Month 7-12						Month 1-6						Month 7-12						Month 1-6					
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6
1																															
2a																															

PROJECT RESULTS

Progress against indicators

Please include the latest cumulative data for the indicators agreed during project planning and inception, as set out in your MEL plan and baseline data sheet. NB: the quantitative data provided should be broken down as specified in your MEL plan. E.g. # health workers demonstrating improved skills after training broken down by gender and cadre. We have also highlighted an indicator for which we would like you to provide a copy of a completed data collection tool, as set out in your MEL plan. **In the last two columns, please only report on progress for this reporting period and avoid repeating information you shared in previous reports.**

Indicator	Baseline	Target	Cumulative data	Review of overall progress <i>Has the target been reached for the indicator? If not, why?</i>	Notes on data collection, management and interpretation <i>Where did the data come from, how reliable is it, what challenges have you faced in collecting and managing it, how meaningful is it as a measure of progress?</i>
Output 1:					
Output 2:					
Outcome 1:					
Outcome 2:					
Goal:					

Project Achievements

3.2.1 Other project achievements within the reporting period

The agreed indicators are the core quantitative data that we expect to demonstrate progress in your project, but your project plan and grant application set out other anticipated results. Please summarise below any significant progress, anticipated or not, which you have observed during this reporting period that relates to the project objectives. Maximum 300 words.

3.2.2 Overview of project highlights

Within the lifetime of your grant, what have been your project's most significant results and why? Think widely about the influence that your project has had, which may be beyond the objectives stated in our project plan (outputs, outcomes, goal).

Maximum 300 words.

Sustainability Of Results

Please rate the sustainability of each of your project outcomes and goal and include brief notes on evidence, barriers and lessons learnt. Select your rating by highlighting the relevant value on the scale from 1 (= not sustainable) to 5 (=fully sustainable).

Indicator	On a scale from 1 to 5, how sustainable are your project outcomes/goal?	What is your evidence of sustainability and any barriers identified?	What have you learnt through your efforts to sustain these results?
Outcome 1:	1 2 3 4 5		
Outcome 2:	1 2 3 4 5		
Goal:	1 2 3 4_ 5		

M&E REVIEW

What has worked well with regards to your M&E activities since the start of your project? In light of any challenges experienced, what would you do differently?
Maximum 300 words.

Project Beneficiaries

3.4.1 Beneficiary feedback

Please provide us with at least two quotes from overseas health workers, partners, stakeholders, patients, UK volunteers, etc., giving comments on the project or the progress achieved. Please include only those quotes that describe change in practice, rather than course feedback. Add more lines if necessary.

Full name, location and job title (if applicable)	Quote

Volunteer And Training Numbers

Each of the health partnerships has been asked by THET to gather standard data on training numbers, training days, volunteer numbers and volunteer days. These requirements are also included in the M&E work plan. Please complete the tables and questions below. ***In case of doubt about definitions and which numbers to include, please refer to the narrative reporting FAQ provided by THET. Please be careful not to double-count data you have previously reported.***

Number of health workers participating in training or mentoring

Please aggregate numbers for all training and mentoring conducted in this reporting period – there is no need to report each training course separately. Use the different columns, a – d, to disaggregate the training figures by who the trainees were trained by e.g. were nurses trained by local trainers (your ToTs) or by the UK trainers (volunteers)? NB Local trainers are those previously trained by the UK team (TOT trainees). Where a trainee has received some training from the UK team and some from local trainers, please only fill in the ‘UK & local trainers’ column. ***For guidance on which numbers to include please review the FAQ.***

Cadre	No. of Health Workers trained by							
	a) Local trainers		b) UK trainers		c) UK & local trainers		d) Other	
	Female	Male	Female	Male	Female	Male	Female	Male
<i>Medical</i>								
<i>Nursing</i>								
<i>Occupational Therapy</i>								
<i>Pharmacy</i>								
<i>Psychology</i>								

Please report the total number of training days provided by the project in this reporting period. This includes on-the-job training days, mentoring time, practical training and classroom based training multiplied by the number of health workers trained. You can use the comment box to explain how you calculated these figures. Add more rows if necessary.

Cadre	Total number of training days provided (no. of trainees multiplied by training days)	Further comments
<i>Medical</i>		
<i>Nursing</i>		

<i>Occupational Therapy</i>		
<i>Pharmacy</i>		
<i>Psychology</i>		

Volunteer initials	Gender	Cadre	Agenda for change band / medical grade	Days spent volunteering in UK	Days spent volunteering overseas

	Days spent in the UK by overseas partners
Female	
Male	

Volunteer professional development

THET and others have worked with Health Education England to produce a toolkit to help international health volunteers collect evidence of professional development while on placement. Please encourage your volunteers to access the toolkit at <http://bit.ly/1CX8K0s> before they go, and to fill in the anonymous online survey at <https://www.surveymonkey.com/r/VolunteerAppraisalHPS> once they have returned and had an annual appraisal / PDR / revalidation.

In these final stages of the HPS, the response rate to this survey is still quite low considering the number of UK health workers who have volunteered through health partnership projects. To ensure that robust evidence on the benefits of international volunteering for the UK health system can be presented to DFID in the HPS Completion Report, we would greatly appreciate if you could circulate the survey link to all your volunteers for past and present HPS projects and encourage them to complete it if they haven't already done so.

In order for THET to assess the response rate to the survey, please complete the table below.

Survey dissemination data (please provide cumulative figures)	No.

PARTNERSHIP DEVELOPMENT

Partnership Development Goals

Below we have listed the partnership development areas you specified in your partnership development plan. Please summarise your overall progress in these areas, and provide concrete examples to illustrate this.

Partnership development area	Overall progress since start of project	Examples

Other Changes To The Partnership

If your health partnership has developed in other significant ways in the last six months, please summarise them here. Maximum 200 words.

--

Partnership Overview

How has your partnership evolved through the lifetime of the project in terms of quality and capacity to deliver?

--

The Future Of The Partnership

How do you plan to work together in the coming months and years?

--

LESSONS LEARNT

In this section we would like you to reflect upon the last six months and tell us about some other lessons you have learnt. They might relate to partnership development, project implementation, project and financial management, monitoring and evaluation or other aspects of your work. They may relate to very specific experiences (eg a meeting or conversation) or larger pieces of work.

We have asked the UK and the overseas country lead partners to report separately, so that we may understand more about your different perspectives. However, if the UK partner's lessons are the same as the overseas country partner's, please note it – there is no need to repeat yourselves.

Overseas Country Lead Partner's Perspective

Describe one piece of work that went better than expected	What made it so successful?
Describe one piece of work that went worse than expected	What did you do to address it?

UK Lead Partner's Perspective

Describe one piece of work that went better than expected	What made it so successful?

Describe one piece of work that went worse than expected	What did you do to address it?

THET'S PERFORMANCE

How satisfied you are with the support you have received from THET in the last 12 months? Please fill out a short survey (only two questions) by clicking on the link below. All your answers will remain anonymous.

<https://www.surveymonkey.co.uk/r/THETassistance16-17>

FINANCES

Were the funds solely managed in the UK or were funds transferred to an overseas partner and managed by both partners?

Please reflect on the chosen financial management arrangements that were implemented for this project and detail any particular challenges you faced in relation to managing the project budget and expenditure within the partnership (eg. transferring money overseas, exchange rates) and how these were overcome.

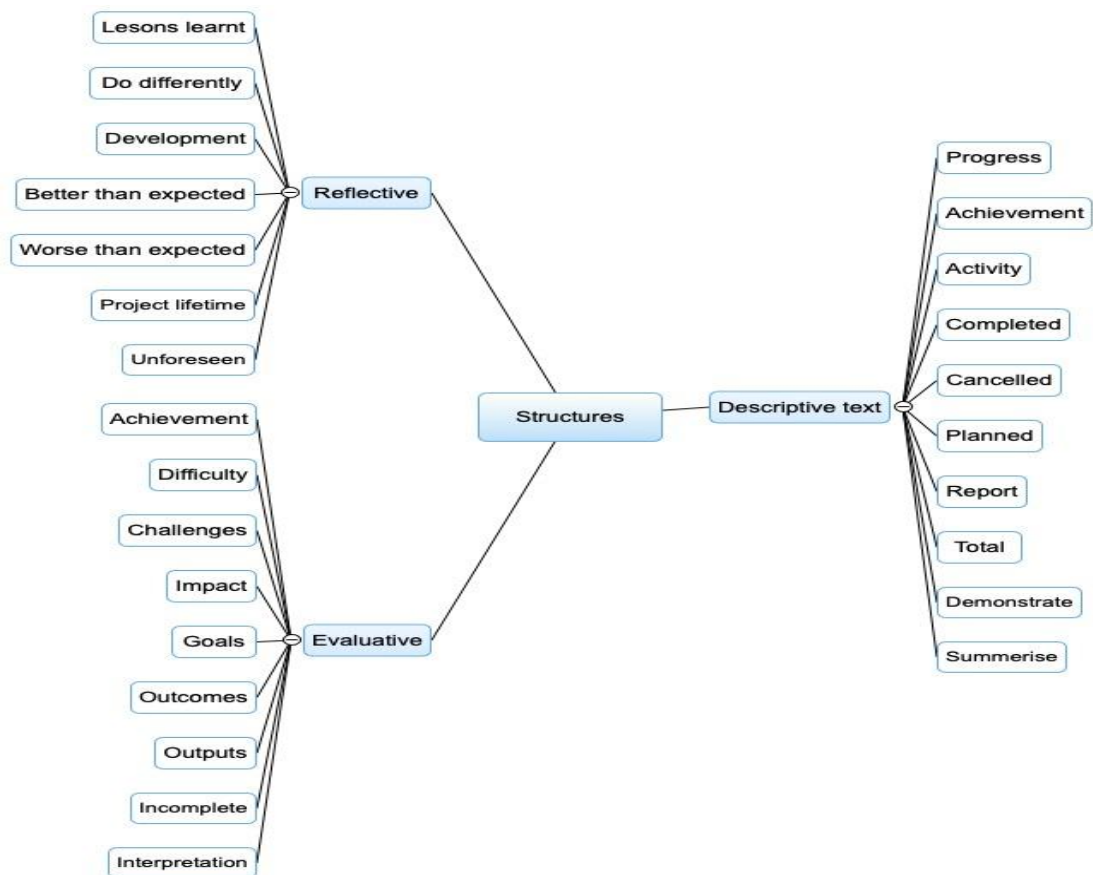
OTHER SOURCES OF INFORMATION ABOUT YOUR PARTNERSHIP AND PROJECT

Please use the table to give summary information that is not limited to the HPS project and which will help THET to build a picture of your Health Partnership e.g. articles published, marketing or fundraising materials, photos. This information will provide valuable context for our work advocating the health partnerships model. Add more lines if necessary.

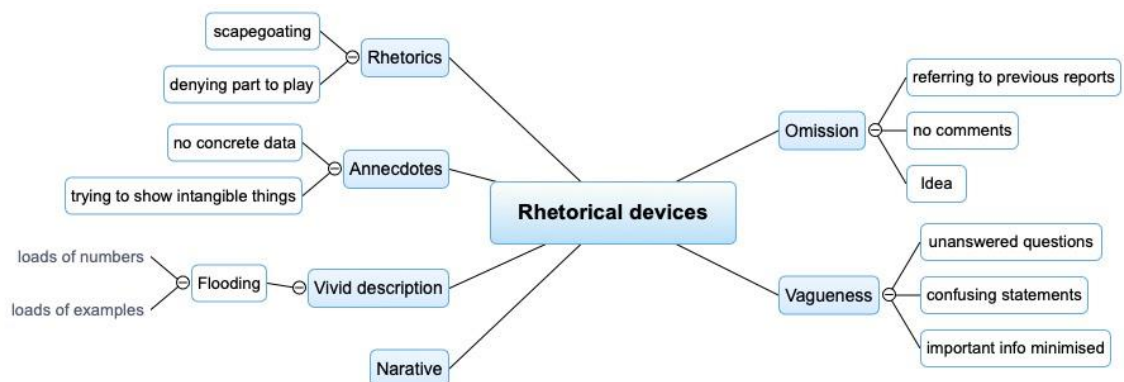
Source eg publication title, website name	Where we can access it eg hyperlink, attachment

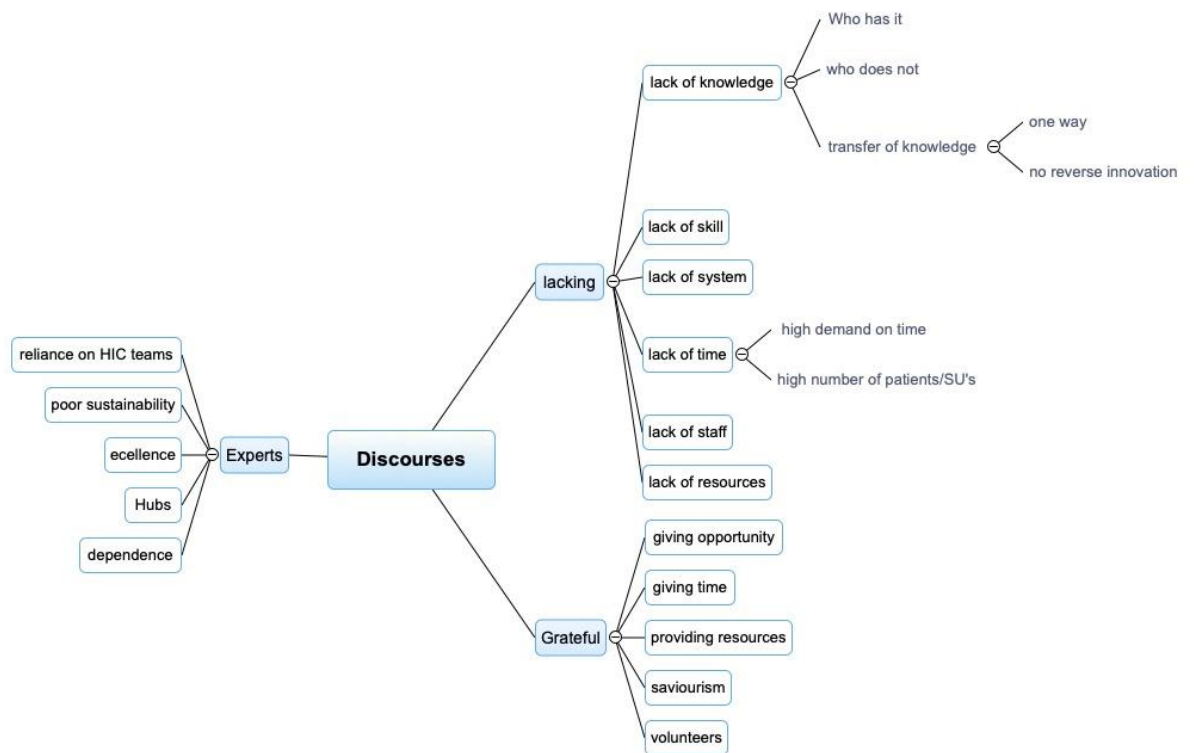
7.6 Appendix F – Example of Analysis

The following is a mindmap of the key terms from the questions asked by evaluators within the report template which led to the creation of meta-structures of Descriptive, Reflective and Evaluative text.



The following is the inductive terms used to code the authors responses in the reports. They identify rhetorical devices and discourses.





7.7 Appendix G – SREC Confirmation

SCHOOL OF PSYCHOLOGY RESEARCH ETHICS COMMITTEE

NOTICE OF ETHICS REVIEW DECISION

FOR Research Involving Human Participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Mark Finn

SUPERVISOR: Kenneth Gannon

STUDENT: Kumar Birch

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: A Critical Analysis of UK International Health Partnerships: The Discourses of Mental Health

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED WITH MINOR CONDITIONS

Minor amendments required (for reviewer):

It is stated that social media and the researcher's UEL account will be used for recruitment but please ensure that NHS lines of communication are not used to recruit participants

Font size of the participant invitation letter could be larger (12 font)

Please address the incomplete sentence in the "What will happen to your data" section in the participant invitation letter ✓

It is stated that after the study audio recordings will be deleted. Please consider destroying names and contact details of participants at that time too, and specifying this in the invitation letter ✓

No interview schedule or example interview questions are attached to the application and should have been. The application is approved on condition that the supervisor approved the interview schedule before data collection commences

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*): Kumar Birch

Student number: U1622764

Date: 24/05/2018

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)



LOW

Reviewer comments in relation to researcher risk (if any).

None

Reviewer (*Typed name to act as signature*):

Mark Finn

Date: 24/04/18

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard